Dr. V. Lekhi Assessment & Referral Form

GIMBEL EYE CENTRE

Patient referred for: ☐ Refractive Cataract Assessment/Second Opinion ☐ Retina ☐ Other
☐ Secondary Cataract/YAG laser Tx ☐ Glaucoma

Referral Date (m/d/y): _____

Patient Name (Dr./Mr./Mrs./Ms./Miss): _____ Sex: ☐ Female ☐ Male

DOB (m/d/y): _____ Alberta Health Care #: _____

Address: _____ E-mail: _____

Telephone (res): _____ (bus): _____ (cell): _____

City: _____ Prov/State: _____ Postal/Zip: _____

If the Patient may not be reached or would have difficult answering questions, please indicate a contact person below:

Name of Contact Person: _____ Relationship to Patient: _____

Telephone (res): _____ (bus): _____ (cell): _____

Assessing Doctor Name: _____ Type of doctor: ☐ OD ☐ MD ☐ OPH

Address: _____ PRACID #: _____

Telephone: _____ Facsimile: _____

City: _____ Prov/State: _____ Postal/Zip: _____

Patient Health History

Ocular History (e.g., Injury, Amblyopia, Dry Eye, etc.): _____

_____

If Patient has had previous eye surgery, please indicate type of sx: OD _____

OS _____

Name of Surgeon: _____ Location: _____

Date of Sx (m/d/y): _____ Was a lens implanted? ☐ Yes ☐ No

Please Check:

☐ Diabetes	☐ Mobility Problem	☐ Benign Prostatic Hypertrophy	☐ Heart
☐ Asthma	☐ Auto Immune Disease	☐ Immune Deficiency	☐ Language Difficulty
☐ Hepatitis	☐ Ocular Herpes Zoster	☐ Ocular Herpes Simplex	☐ Hearing Difficulty
☐ Atopy	☐ Pregnancy/Nursing	☐ Collagen Vascular Disease	☐ Hypertension

☐ Other health problems or concerns (If yes, please specify):

_____

List medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: _____ Systemic: _____

_____ _____

_____ _____

List allergies to food (include nuts and shellfish) medications, surgical tape, eye drops, iodine &/or latex:

_____

_____ Specify if allergies are: ☐ Airborne ☐ Contact

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Assessment & Referral Form cont'd

GIMBEL EYE CENTRE

Patient Name: _____

Does Patient have cataracts? ☐ Yes ☐ No If *Yes,* indicate: ☐ OD ☐ OS

Does Patient have glaucoma? ☐ Yes ☐ No If *Yes,* indicate: ☐ OD ☐ OS

Current or last IOP: _____ OD _____ OS

IOP measured by: ☐ AT ☐ NCT

Does Patient have retinal pathology? ☐ Yes ☐ No If *Yes,* indicate: ☐ OD ☐ OS

Any abnormalities of the cornea? ☐ Yes ☐ No If *Yes,* indicate: ☐ OD ☐ OS

If *Yes,* please explain: _____

_____

Any abnormalities of the iris? ☐ Yes ☐ No If *Yes,* indicate: ☐ OD ☐ OS

If *Yes,* please explain: _____

_____

Best Corrected Visual Acuity OD 20/ _____ OS 20/ _____

Current Spectacles Rx OD _____ OS _____

Does the patient wear prism(s) in his/her current spectacles? ☐ Yes ☐ No

Would you prefer that our office performed follow-up care? ☐ Yes ☐ No ☐ Other

If *Other,* please specify: _____

Does Patient wear contact lenses? ☐ Yes ☐ No

If *Yes,* indicate: ☐ Hard ☐ Soft ☐ Rigid Gas Permeable ☐ Other, please specify: _____

☐ Instructed to leave out contact lenses for ____ days prior to assessment

Comments: _____

_____

_____

_____

Has Gimbel Eye Centre seen this Patient previously? ☐ Yes ☐ No

Signature of Assessing Doctor: _____

For Office Use Only

Patient ID: _____

Appointment Date: _____ Appointment Type: _____

Comments: _____

_____

_____

☐ **Gimbel Eye Centre Calgary** Fax: (403) 286-2943 ☐ **Gimbel Eye Centre Calgary** Phone: (403) 286-3022