STELLAR
INTEGRATED EYE CARE

REFERRAL FORM

URGENT CASES CALL 780-652-2033
(Booked immediately to 1 week)

◯ ANY DOCTOR ◯ DR. MIRAL MEHTA, MD

Referral Date: DD/MM/YY | **Ideal Appt:** ◯ URGENT (Please Call) ◯ 1 – 2 weeks ◯ 1 month

REFERRING DOCTOR:

Dr. Name: _____ Dr. PRAC ID: _____

Office Name: _____ Location: _____

Phone Number: _____ Fax Number: _____

For optometrists: Are you interested in Co-Management? ◯ YES ◯ NO

PATIENT INFO:

◯ 18 yrs or older ◯ Minor under 18 yrs **(Please do NOT include Phone # for Minors)**

First Name: _____ Last Name: _____ Gender: ◯ Male ◯ Female

Date of Birth: DD/MM/YY _____ ULI/PHN #: _____ ◯ _____

Home Phone Number: _____ Cell Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

MEDICAL INFO:

Past Medical History: _____

Current Medications: _____

Allergies: _____

REASON FOR REFERRAL:

◯ Dry Eye / Ocular Irritation / Itchiness
◯ Decreased Visual Acuity
◯ Post Vitreous Detachment
◯ Glaucoma
◯ Eye Lid
◯ Botox
◯ Diabetic Ocular Exam
◯ Neuro-Ophthalmology
◯ Pediatric Exam
◯ Laser: LPI / SLT / YAG cap
◯ Other: _____

PLEASE FAX TO 587-689-2129, THANK YOU!

STELLAR
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