STELLAR
INTEGRATED EYE CARE

REFERRAL FORM

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

◯ ANY DOCTOR

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)**

Gender: ◯ Male ◯ Female ◯ ____________

First Name: ____________ Last Name: ____________

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
◯ Cataracts
◯ Pediatric Exam
◯ Laser: LPI / SLT / YAG cap
◯ Other: ____________

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

STELLAR
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