



FRASER VALLEY

CATARACT & LASER

GENERAL MEDICAL AND SURGICAL OPHTHALMOLOGY REFERRAL FORM

(clinics are permitted to use their own form)

Preferred Location: Abbotsford Surrey Coquitlam
Preferred Doctor: Dr. Chu Dr. King Dr. Moosbrugger Dr. Payne Dr. Ekhlasi No preference
 Other _____

Date (mm/dd/yr): _____ **Referring Doctor & MSP#:** _____

Referring Office Address: _____

Tel. / Fax Number: _____

PATIENT INFORMATION

Name: _____ DOB (mm/dd/yr): _____

PHN#: _____

Address: _____

Home/Cell Tel #: _____ Work/Alternative Tel: _____

Diagnosis: _____

History & Examination: _____

Please indicate request(s) if appropriate:

- Cataract Evaluation (urgent/non-urgent)
- LASIK/PRK Evaluation
- Intraocular Collamer Lenses (ICLs)
- Refractive Lens Exchange (RLE) Evaluation
- Routine Evaluation
- Corneal Cross Linking
- Humphrey Visual Field (HVF)
- Optical Coherence Tomograph (OCT)
- Other (urgent/non-urgent) _____

Oculoplastics:

- Entropion/ Ectropion
- Brow Lift/ Blepharoplasty
- Ptosis Repair
- Blocked Tear Duct
- Eyelid Lesion
- Chalazion
- Special Requests: _____

Cornea:

- Pterygium/Pinguecula
- Recurrent Erosion/Dystrophy
- Dry Eye

Laser:

- SLT
- YAG LPI
- YAG Capsulotomy or vitreolysis
- Retinal Laser Photocoagulation

Retina:

- Diabetes
- Age-Related Macular Degeneration
- Vein Occlusions

Neuro-Ophthalmology:

- Botox for Blepharospasm
- Botox for Hemifacial Spasm
- Botox for Migraines

Glaucoma:

- Evaluation
- iStent