Place Patient Form Label Here

OPHTHALMOLOGY REFERRAL

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Ophthalmology Referral

St. Paul's Hospital Eye Clinic
Level 2 (Main Floor) Providence Building
Phone: 604-806-8168 Fax: 604-806-8058

Referral Date:	Referral Source: _____ Contact #: _____ Billing #: _____
Patient's Name: _____ Phone No: _____	DOB: (mmm/dd/yy) ☐ Male ☐ Female ☐ Other
Patient's Home Address: _____ _____ _____	PHN: _____ ☐ WorkSafe ☐ ICBC
Language(s):	☐ Interpreter needed

Key/alternate contact: (call this person for appointments) ☐ Yes ☐ No

Name: _____ Phone(s): _____

Relationship: _____ _____

Family Physician: Name: _____

Office Phone No: _____ Office location: _____

REASON(S) FOR REFERRAL: _____

Level of urgency:
☐ Urgent
☐ Routine

Service requested:
☐ General
☐ Neuro-Ophthalmology
☐ Retina
☐ Infectious Eye Disease (HIV/AIDS)
☐ Uveitis and Ocular Immunology
☐ Other: (specify) _____

All New Patients will be seen by the first available ophthalmologist of a particular service.

Please indicate a specific treatment provider if required: _____

Please fax completed Referral, along with other relevant medical information to the St. Paul's Hospital Eye Clinic: 604-806-8058