

**Please fax to 403-724-0107**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Dr. Colleen Gnyp | <input type="checkbox"/> Dr. Joanna Komar     | <input type="checkbox"/> Any Provider |
| <input type="checkbox"/> Dr. Rima Sabbah  | <input type="checkbox"/> Dr. Abdelkader Soufi |                                       |

**Referring Provider Information (include PRAC ID and fax):**

Would like a report back

**Patient Information:**

Name (LAST, First):	AHC #:
DOB (dd-mm-yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____
Phone:	Email:

<u><b>Urgent</b></u>	<u><b>Routine Screening/Monitoring</b></u>								
<input type="checkbox"/> <b>Same day appointment requested</b>  <input type="checkbox"/> Blurry vision (sudden onset) <input type="checkbox"/> Double vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eyelid infection/inflammation <input type="checkbox"/> Flashing lights and/or floaters <input type="checkbox"/> Foreign body <input type="checkbox"/> Headaches <input type="checkbox"/> Red eye – conjunctivitis – iritis - keratitis <input type="checkbox"/> Visual field loss <input type="checkbox"/> Rule out narrow-angle glaucoma (some medications can induce an attack in predisposed individuals) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adult eye examination <input type="checkbox"/> Cataract <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Diabetic retinal eye exam <input type="checkbox"/> Dry eyes <input type="checkbox"/> Drugs with adverse ocular effects <table border="0" style="margin-left: 20px;"> <tr> <td><input type="checkbox"/> Accutane</td> <td><input type="checkbox"/> Ozempic</td> </tr> <tr> <td><input type="checkbox"/> Ethambutol</td> <td><input type="checkbox"/> Steroids</td> </tr> <tr> <td><input type="checkbox"/> Gilenya</td> <td><input type="checkbox"/> Tamoxifen</td> </tr> <tr> <td><input type="checkbox"/> Hydroxychloroquine</td> <td><input type="checkbox"/> Other</td> </tr> </table> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Pediatric eye examination <input type="checkbox"/> Pediatric strabismus <input type="checkbox"/> Post stroke <input type="checkbox"/> Visual field testing <input type="checkbox"/> Other: _____	<input type="checkbox"/> Accutane	<input type="checkbox"/> Ozempic	<input type="checkbox"/> Ethambutol	<input type="checkbox"/> Steroids	<input type="checkbox"/> Gilenya	<input type="checkbox"/> Tamoxifen	<input type="checkbox"/> Hydroxychloroquine	<input type="checkbox"/> Other
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**Additional details:**