



St. Paul's Hospital Eye Clinic
 Level 2 (Main Floor) Providence Building
 Vancouver BC, V6Z 1Y6
 Phone: 604-806-8168 Fax: 604-806-8058

OPHTHALMOLOGY REFERRAL

Referral Date: _____	Referral Source: _____		
	Contact #: _____		Billing #: _____
Patient's Name: _____		DOB: (mmm/dd/yy) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Phone No: _____			
Patient's Home Address: _____ _____ _____		PHN: _____ <input type="checkbox"/> WorkSafe <input type="checkbox"/> ICBC	
Language(s): _____ <input type="checkbox"/> Interpreter needed			
Key/alternate contact: (call this person for appointments) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name: _____		Phone(s): _____	
Relationship: _____			
Family Physician: Name: _____			
Office Phone No: _____		Office location: _____	
REASON(S) FOR REFERRAL: _____			
Level of urgency: _____ <input type="checkbox"/> Urgent <input type="checkbox"/> Routine			
Service requested: <input type="checkbox"/> General <input type="checkbox"/> Infectious Eye Disease (HIV/AIDS) <input type="checkbox"/> Neuro-Ophthalmology <input type="checkbox"/> Uveitis and Ocular Immunology <input type="checkbox"/> Retina <input type="checkbox"/> 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**

