Mitchell Eye Centre

Your eyes. **Our focus.**

☐ **Dr. Robert Mitchell**
Dry Eye
General
Cataract
Refractive

☐ **Dr. Patrick Mitchell**
Retina Medical and Surgical
Cataract

☐ **Dr. Brett Poulis**
General
Uveitis

☐ **Dr. Jason Wesolosky**
General

☐ **Any Provider**

Patient Information

Name: ______________________________ **DOB:**______________ ☐ **M** ☐ **F**

Address: ____

Phone: ______________________ **Cell:** ______________________

AHC# ______________________

Referring Clinic Information

Referring Physician: ______________________ **Email:** ______________________

Phone: ______________ **Fax:** ______________ **Date:** ______________________

Practice ID# :______________________

Urgency of Referral: ☐ Urgent ☐ Within a Week ☐ Within a Month ☐ Elective

This referral is for transfer of care: ☐ Yes or ☐ No

Co-Management of this patient is desired: ☐ Yes or ☐ No

Conditions

- ☐ **ARMD (wet / dry)**
- ☐ **Vein Occlusion**
- ☐ **Diabetic Retinopathy**
- ☐ **Diabetic Maculopathy**
- ☐ **Retinal Tear/Hole**
- ☐ **Epiretinal Membrane**
- ☐ **Macular Hole**
- ☐ **Vitreomacular Traction**
- ☐ **Vitreous Detachment**
- ☐ **Retinal Detachment Mac On/Off**
- ☐ **Retinal Lesion**
- ☐ **Nevus**
- ☐ **Cataract**
- ☐ **Conjunctiva**
- ☐ **Cornea**
- ☐ **Dry Eye**
- ☐ **Eyelid/Orbit**
- ☐ **Glaucoma**
- ☐ **Lacrimal / Tearing**
- ☐ **Optic Nerve**
- ☐ **Pterygium**
- ☐ **Refractive**
- ☐ **Strabismus (adult/children)**
- ☐ **Sudden Loss of Vision**
- ☐ **Uveitis**
- ☐ **Other** ______________

Comments

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Please fax this form to our office at (403) 258-2704 with any supplement workup/information

Mitchell Eye Centre
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