ORBIT
EYE CENTRE

Dr. Chirag R. Shah
MBBS | DO | MD | FRCSC
Medical Retina
General Ophthalmology
Refractive Surgery

Please Fax Referral to 403-255-7764

Appointment will be booked with Patient directly and confirmation will be faxed back

Reason for Referral – Indicate OD / OS / OU

Medical Retina

- ☐ Diabetic Retinopathy
- ☐ Hypertensive Retinopathy
- ☐ Vascular Occlusions: BRVO/CRVO/CRAO/BRAO
- ☐ Age Related Macular Degeneration: Wet/Dry
- ☐ Retinal Tear
- ☐ Retinal Dystrophy/Retinopathy
- ☐ Maculopathy: Possible Cause ______________________
- ☐ Uveitis
- ☐ Nevus/Melanoma
- ☐ Glaucoma
- ☐ Other: ______________________

____________ Non-urgent

____________ Semi-urgent

____________ Urgent

Last Seen: ______________________ IOP: OD ________ OS ________

Refraction OD: ______________________ VA: ________

OS: ______________________ VA: ________

Additional Comments: ____

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Patient Name: ______________________ DOB: ____________ PHN# ____________

Phone: ______________________ Alternate Phone: ______________________

Referring Doctor: ______________________ Referring Office Fax #: ______________________

Referring Office Phone # ______________________ Date of Referral: ______________________

Practitioner ID#: ______________________ Doctor's Signature: ______________________

*24 hours notice is required to change or cancel an appointment or there will be a $75.00 charge.