Dr. Michael Ashenhurst
Eye Physician & Surgeon
933 - 17 Avenue SW, Suite 344, Calgary, Alberta T2T 5R6
Phone: 403-245-3171 Fax: 403-245-4205

Patient Name: Last_____ First _____ AHC#: _____

DOB: Mon/ Day/ Year _____/_____/_____ Gender M / F/ O Family Physician _____

Email: _____Cell Phone: _____Other Phone_____

Address: _____

For Pediatric patients Mother_____ Father _____

Please note: We contact patients directly with the appointment date and time by **email and/or cell phone** .
If this information is not provided the referral process may be delayed.

Reason for referral

Cataracts _____

Orbital disease/Graves___

Ptosis _____

Eyelid Malposition____

Tearing _____

Eyelid lesion or Stye _____

Medical Botox _____

Cosmetic Eyelid concern ____

Mohs

Other: _____

History

Systemic Meds_____

Allergies _____

Eye drops Right eye _____

Eye drops Left eye _____

Emergency Contact _____

Emergency Contact phone _____

Pharmacy Phone Number _____

Visual Acuity: Right: _____Left:_____

IOP: Right: _____ Left:_____

Refraction: Right:_____

Left: _____

Notes: _____

_____

Referring Doctor Name:	PRACID	Office Address Stamp:
Office Phone:	Office Fax:	
Specialty	Date of Referral:	