Dr. Vivian Hill
Eye Physicians and Surgeons
Suite 344-933 17th Avenue SW
Calgary, AB T2T 5R6
Phone: (403) 245-3171 Fax: (403) 245-4205

Dear Doctor:

We are happy to announce that Dr. Hill is now accepting diabetic check and glaucoma screening patients.

Please find our new referral form on our website.

Dr. Hill is happy to accept the following referrals:

- Pediatric and adult strabismus and diplopia
- Pediatric amblyopia, refraction, glasses check, and myopia control
- Other pediatric concerns
- Adult and peds styes and lid lesions
- Diabetic checks
- Glaucoma screening
- Adult and peds IIHT/papilledema and optic neuritis
- Medical and cosmetic Botox and fillers
- Pterygium

Clinic Administration
Dr. V. Hill Ophthalmology Clinic
344, 933 - 17 Avenue SW
Calgary, AB T2T 5R6
T: 403.245.3171 F: 403.245.4205
Website: www.ashenhursteye.com
Email: reception@ashenhursteye.com

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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:

Adult & Pediatric Strabismus _____

Optic neuritis or IIH/ Papilledema ____

Amblyopia, Pediatric Refraction & Glasses _____

Myopia Control _____

Cosmetic filler/Botox _____

Medical Botox _____

Pediatric & Adult Stye & Lid Lesion_____

Pterygium _____

Glaucoma Screening _____

Diabetic Check _____

Other Pediatric Concern _____

Other: _____

History:

Systemic Meds _____

Allergies _____

Eye drops Right eye _____

Eye drops left eye _____

Emergency Contact _____

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:	