Referral to Dry Eye Clinic of Regina

The Dry Eye Clinic of Regina 2627 Star Lite St,Regina, SK S4V 3E1

Phone : (306) 761-3937

Fax : (306) 761-3942

Referring Physician Information

Referring Physician's Name			Date *(Month DD, YYYY)*
Office Address			
City	Province	Postal Code	Phone
Fax	Primary Care Physician		

Patient Information

Spectrum Chart Number	Patient Name *(first, middle initial, last)*			Sex ☐ Male ☐ Female
Address				County *(Optional)*
City		Province	Postal Code	Birth Date *(Month DD, YYYY)*
Home Phone	Alternate Phone *(Cell or Work)*	Parent's Name *(If minor)*		
Maiden Name *(Optional)*		Spouse's First Name *(Optional)*		
Patient Insurance Information *(If available)*		Does the patient need an interpreter? ☐ Yes ☐ No		
		If yes, what language?		

Appointment Request

Reason for referral/symptoms/diagnosis (please be specific). Submit any pertinent medical records.

Dryness,Grittiness or Scratchiness

Soreness or Irritation

Burning or Watering -

Vision Loss

Eye Fatigue

Blepharitis

Stye

Painful Eye

Do you have fluctuating vision problems? (That can be corrected with blinking)

Never - Sometimes Frequently A Lot /Always

Do you use eye drops and/or ointment? YES NO

If yes, which drops do you use?

You will receive confirmation once the appointment is scheduled

Preferred Method for Communication Letter Fax Phone / Pager

©thespectrumeyecentre.com