GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

# Doctor Referral Form

**Direct Doctor Referral Line**
616.456.2020 or 800.968.2600
Fax 616.365.2076 or 616.588.6526

Date: _____

See every moment.®

## PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Referred for consultation to Doctor (please print doctor's name): _____

## SCHEDULE AND LOCATION

Appointment: **DATE** _____ **TIME** _____

Please indicate location:

☐ 7 Mile ☐ East Beltline ☐ Walker ☐ Grandville ☐ 68th St.
☐ Greenville ☐ Ionia ☐ Holland ☐ Caledonia

## APPOINTMENT INFORMATION

Reason for consultation: _____

Additional information related to the referral: _____

_____

Most recent refraction (if applicable) **DATE:** _____

OD_____ SPH_____ CYL AXIS_____ = 20 / _____

OS_____ SPH_____ CYL AXIS_____ = 20 / _____

ADD + _____ = 20 / _____

ADD + _____ = 20 / _____

## IF PATIENT IS REFERRED FOR CATARACT SURGERY

☐ I agree to provide post-operative care for this patient following cataract surgery and the *Request for Cataract Co-Management Form* has been completed and signed by both my patient and me, the referring doctor.

## REFERRING DOCTOR

Doctor Signature: _____

Doctor Printed Name: _____

Address: _____

Phone: _____ FAX: _____

*This form is also available online at www.seeitclear.com/referring-doctors*