GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Partner Referral Form

Direct Referral Line
616.456.2020 or 800.968.2600
Fax 616.365.1130

See every moment.®

Date: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

Doctor or specialty preference: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Patient phone: (_____)_____ Patient email: _____

Patient SS #:_____ Primary care physician: _____

Insurance: _____ Policy/Group #_____

Is patient referred by Veterans Choice? Yes No (Please circle one)

APPOINTMENT INFORMATION

Reason for consultation:_____

Additional information related to the referral: _____

_____

Diagnosis: _____ Diagnosis code:_____

Urgency of referral: Urgent 1-2 weeks 1 month first available (please circle one)

Any special needs for the patient? (i.e. wheel chair, interpreter, etc.) _____

***Please fax most recent office visit notes with this referral form.**

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: _____

FOR GRAND RAPIDS OPHTHALMOLOGY USE ONLY

Patient is scheduled at Grand Rapids Ophthalmology: Date: _____ Time:_____

Doctor scheduled with: _____ Office location: _____

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