GRAND RAPIDS OPHTHALMOLOGY

Direct referral line 616.456.2020
Fax 616.365.1130

PARTNER REFERRAL FORM

Date: _____

PATIENT INFORMATION

Name _____ DOB: _____ Gender_____

Address _____

Phone (____)_____ Email: _____

Emergency Contact _____ Phone (____)_____

Social Security # _____ Primary Care Physician _____

Primary Insurance _____ Policy #_____ Group # _____

Specialty or Doctor Preference _____

APPOINTMENT INFORMATION

Reason for Consultation _____

Diagnosis _____ Diagnosis Code _____

Urgency of Referral ☐ Urgent ☐ 1-2 Weeks ☐ 1 Month ☐ First Available

If optometry referral, attach exam notes and note date of last dilated eye exam _____

Additional Referral Notes _____

_____

Patient Special Needs Notes (wheelchair, interpreter, etc.) _____

_____

REFERRING DOCTOR

Doctor Name _____ NPI# _____

Doctor Signature _____

Address _____

Phone (____)_____ Fax (____)_____

Contact Person _____ Email: _____

CO-MANAGEMENT REFERRAL 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.