Print Form

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Grand Valley LASIK Institute

# Patient Referral Information

DATE:_____

DR. REFERRED BY: _____

DR. ADDRESS: _____

DR. PHONE:_____FAX_____

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT PHONE: Home# _____Work #_____

PATIENT DAT OF BIRTH_____

PATIENT INSURANCE: _____

INSURNACE #'S: _____

REASON FOR REFERRAL (PLEASE CIRCLE)

REFRACTIVE VISION CORRECTION ☐

CATARACT EVALUATION ☐

CORNEAL EVALUATION ☐

OTHER_____

HISTORY:_____
_____

Manifest Refraction OD_____ BCVA_____ Tonometry_____mmHg @ _____
OS_____BCVA_____ Tonometry_____mmHg @ _____

Anterior Segment:_____
Posterior Segment: _____

Comments:_____
_____
_____

Thank you for the referral! We will contact your patient the same day we receive your fax to schedule an appointment and fax back their appointment information to you.