WEST MICHIGAN
Eye & Laser

Patient Referral Form

DATE ______________________

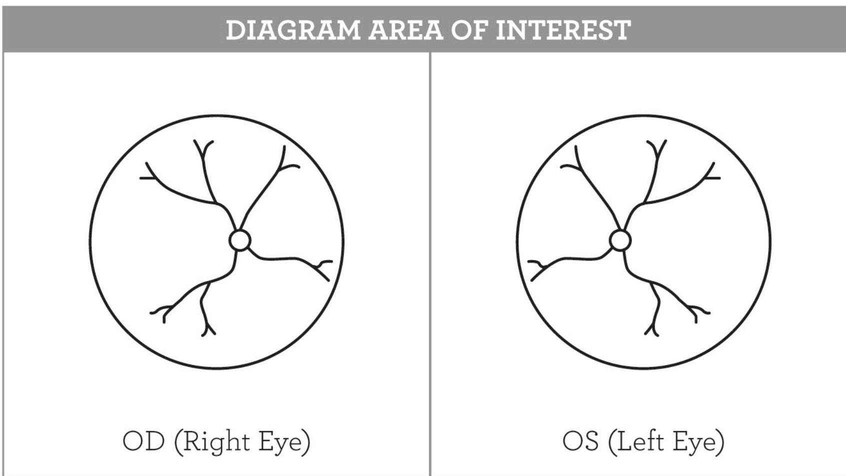
PATIENT NAME ______________________ PATIENT DOB ______________________

PATIENT INSURANCE ______________________ PATIENT PHONE # ______________________

REFERRAL DOCTOR ______________________ DOCTOR PHONE # ______________________

Diagnosis/Reason for Referral >

- ☐ Cataract
- ☐ LASIK
- ☐ Lids
- ☐ Glaucoma
- ☐ Retina (Diabetic/Plaquenil) Other ______________________
- ☐ Dry Eye
- ☐ Other ______________________



Requested Tests >

- ☐ OCT (Macular/Optic Nerve)
- ☐ Visual Field
  - ☐ 10-2
  - ☐ 24-2
  - ☐ 30-2
  - ☐ Superior 64
  - ☐ Full 120
  - ☐ Matrix FDT
- ☐ Fundus Photos OD OS OU
- ☐ 3D Wavefront
- ☐ Refraction (Rx)

Appointment Preference >
(check one)

- ☐ Monday
- ☐ Thursday
- ☐ Tuesday
- ☐ Friday
- ☐ Wednesday
- ☐ AM
- ☐ PM

DATE OF SCHEDULED APPOINTMENT ______________________ TIME ______________ *am // pm*

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