GRAND RAPIDS OPHTHALMOLOGY
Eye Care | Surgery | Laser Correction

Direct Referral Line: 616-456-2020
Fax: 616-365-1130

PARTNER REFERRAL FORM

DATE: _____

Patient Information

Name: _____DOB: _____Gender _____

SSN (last 4 digits) _____ Email _____ Phone ( ) _____

Address_____

Primary Insurance: _____Policy# _____Group# _____

Primary Care Physician_____ Phone ( )_____

Appointment Information

Referral to Doctor: _____ OR ☐ No Preference, 1st available GRO doctor

Reason for Consultation:_____

Diagnosis: _____ Urgency of Referral: ☐ Urgent ☐ First Available

Comments: _____

Patient Special Needs: ☐ Interpreter- Language_____ ☐ Wheelchair ☐ Other _____

Cataract Co-Management Preferences

Please indicate preferred post operative care. Co-management includes the 90 Day global period. Choose all that apply.

☐1 day post op visit ☐ 1 month post op refraction ☐ All post operative care

☐1 week post op visit ☐ I do not wish to co-manage

***Please sign accompanying Co-management agreement and Patient Consent to proceed.**

If optometry referral, please attach exam notes. Date of last dilated eye exam_____

Additional Referral Notes_____

Referring Doctor Information

Doctor Name: _____NPI#_____

Address: _____Phone_____

Fax: _____Contact Person: _____Email: _____

Doctor Signature: _____