



REFERRAL REQUEST FORM

Referring Provider: _____

Phone _____ Fax _____

Patient Name: _____

DOB _____

Phone _____

OUR SURGEONS:

- NO PREFERENCE**
- GRANT AAKER, M.D.**
Cataract Surgery
Comprehensive Ophthalmology
- JANE MYUNG, M.D.**
Vitreo-Retinal Surgery & Disease
Diabetic Retinopathy
Macular Degeneration
- BLAKE PERRY, M.D.**
Facial / Eyelid Plastic Surgery
- PENNY RECK, M.D.**
Vitreo-Retinal Surgery & Disease
Diabetic Retinopathy
Macular Degeneration
- STEPHEN RECK, M.D.**
Cataract Surgery
Glaucoma Consultation & Surgery
- JAY RUDD, M.D.**
Cataract Surgery
Refractive Surgery
Cornea / External Disease

- Patient will call to schedule appointment
- Please call patient to schedule appointment

Reason for Referral:

- Diabetic Eye Examination
- Cataract Evaluation
- Glaucoma Evaluation *(Patients will be transferred back to referring provider when their glaucoma is stable)*
- Oculoplastic Services
- Retina Services
 - Macular Degeneration Assessment
- Other Evaluation or Treatment (specify)

- Refractive Evaluations (patient will be contacted by Aurora Lasik)
LASIK, PRK, Visian ICL, Refractive Lens Exchange

(ROUTINE VISION REFERRALS)

- NO PREFERENCE**
- TAMMY BURRELL, O.D.**
- KRISTEN CLARK, O.D.**
- HANNAH SONG, O.D.**

Urgency:

- Urgent (within 48 hours)
- Semi-urgent (within 2 weeks)
- Routine

Additional Notes:

LOCATION/CONTACT:

345 College St. SE, Suite C
Lacey, WA 98503

PHONE: 360-456-3200

FAX: 360-456-3894

www.claruseye.com

DOCTORS DIRECT LINE: 360-923-4363

For Administration: Please submit referral form, patient demographics and pertinent records to referrals@claruseye.com OR fax to 360-456-3894. If possible, please have patient bring any imaging studies that have been done with them.

HIPAA Disclosure

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Thank you for your referral!