CLARUS
EYE CENTRE

REFERRAL REQUEST FORM

Referring Provider: _____

Phone _____ Fax _____

Patient Name: _____

DOB _____

Phone _____

☐ 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

Urgency:

☐ Urgent (within 48 hours)

☐ Semi-urgent (within 2 weeks)

☐ Routine

Additional Notes:

_____

_____

_____

OUR SURGEONS:

☐ **NO PREFERENCE**

☐ **GRANT AAKER, M.D.**
Cataract Surgery
Comprehensive Opthalmology

☐ **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

(ROUTINE VISION REFERRALS)

☐ **NO PREFERENCE**

☐ **TAMMY BURRELL, O.D.**

☐ **KRISTEN CLARK, O.D.**

☐ **HANNAH SONG, O.D.**

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.

Thank you for your referral!