CLARUS
EYE CENTRE

Ophthalmologists:

☐ **NO PREFERENCE**

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

☐ **ANTHONY GRILLO, M.D.**
Cataract Surgery
Cornea/External Disease
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
Comprehensive Ophthalmology

Clarus Eye Centre
Main Location (Medical Services)
345 College St. SE, Suite C
Lacey, WA 98503
PHONE: 360-456-3200
FAX: 360-456-3894

For additional locations and associated services, please visit **CLARUSEYE.COM**

For referral materials or to request a meeting regarding referrals with an ophthalmologist, please contact:

Sasha Korthuis
Marketing & Outreach Manager
360-923-4363 Direct
sashak@claruseye.com

REFERRAL REQUEST FORM

Referring Provider: _____

Point of Contact: _____

Phone: _____ Fax: _____

Email: _____

PATIENT INFORMATION

Name: _____

Phone: _____ DOB: _____

Patient Insurance (Primary): _____

Member ID: _____

Patient Insurance (Secondary): _____

Member ID: _____

☐ Patient will contact us to schedule ☐ Please contact patient to schedule

REASON FOR REFERRAL

☐ Cataract Evaluation

☐ Cornea Evaluation

☐ Diabetic Eye Examination

☐ Glaucoma Evaluation (Patient will be transferred back when glaucoma is stable)

☐ Oculoplastic Services

☐ Retina Services ☐ Macular Degeneration Assessment

☐ Routine Vision Services (Eye Exam)- ***Reason:*** _____

☐ Other Evaluation or Treatment - ***Please specify:*** _____

☐ Refractive Evaluation (LASIK, PRK, Visian ICL, Refractive Lens Exchange - Aurora LASIK)

URGENCY

(NOTE: If 'Emergency' or 'Urgent' is selected, please specify reason below in 'additional notes')

☐ Emergency (same day/next day)

☐ Urgent (within 48 hours)

☐ Semi-urgent (within 2 weeks)

☐ Routine

ADDITIONAL NOTES _____

_____

_____

ADMIN: Please submit referral form, patient demographics, most recent DOS chart notes and pertinent records via secure email 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.

TO REACH OUR REFERRAL TEAM: 360-923-4399 OR 360-456-3200, EXT. 1024

Thank you for your referral!