



CLARUS
EYE CENTRE

Ophthalmologists:

NO PREFERENCE

GRANT AAKER, M.D.
Cataract Surgery
Comprehensive Ophthalmology

ANTHONY GRILLO, M.D.
Cataract Surgery
Cornea/External Disease
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
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

HIPAA Disclosure-----

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Thank you for your referral!