



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.**
Vitreoretinal Disease & Surgery
Diabetic Retinopathy
Macular Degeneration
- BLAKE PERRY, M.D.**
Facial & Eyelid Plastic Surgery
- JASON LEWIS, D.O.**
Facial & Eyelid Plastic Surgery
- PENNY RECK, M.D.**
Vitreoretinal Disease
Diabetic Retinopathy
Macular Degeneration
- STEPHEN RECK, M.D.**
Cataract Surgery
Glaucoma Consultation & Surgery

Clarus Eye Centre
Main Location (Medical Services)
345 College St. SE, Suite C
Lacey, WA 98503
PHONE: 360-456-3200
FAX: 360-822-3237

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

For referral materials or to request a meeting with our doctors, please contact:

Sasha Korthuis
Marketing & Outreach
PH: 360-923-4363
sashak@claruseye.com

REFERRAL REQUEST FORM (visit claruseye.com/referrals to submit electronically)

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 **360-822-3237**. If possible, please have patient bring any imaging studies that have been done with them. **You may also submit an electronic form via claruseye.com/referrals.**

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!