GRENE VISION GROUP

PARTNER REFERRAL FORM

Fax 316.609.2177
Direct Referral Line 316.789.7377

REQUIRED INFORMATION

Patient Name | DOB | Phone

Address | City | State | Zip

Insurance | Policy | Group

Email

Doctor | Phone | Fax

Address | City | State | Zip

Diagnosis & code | OD referral: last dilated eye exam

Urgency of referral | Note if doctor preference

Doctor signature | Date

CATARACT REFERRALS

Functional complaint

_____(Doctor Initials) I agree to provide post-operative care for this patient following cataract surgery. The request for Cataract Co-management Form has been completed and signed by both my patient and me, the referring doctor.

ADDITIONAL INFORMATION

Referral, Specialty, or Patient special needs notes (wheelchair, interpreter, etc.)

FAX COMPLETED FORM TO 316.609.2177
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