Vision Rehabilitation Clinic
Western Michigan University Unified Clinics
1000 Oakland Drive - 4th Floor, Kalamazoo, MI 49008
Phone: (269) 387-7064 | Fax: (269) 387-7026

PATIENT REFERRAL FORM

Date: ______________________ Referring Physician______________________ Urgent? ☐Yes ☐No

Phone: ______________________________ Fax: __________________________________

Contact Name: ______________________________________ Phone: __________________________

Patient Name: _________________________________ Gender: ☐M ☐F DOB: ________________

Address: __________________________________ City: ________________ State: ____ Zip: _______

Interpreter Required? ☐ Yes ☐No If yes, which language? ____________________________________

Primary phone: _____________________________ Secondary Phone: ___________________________

Guardian's name (if patient is a minor): ________________________________ Phone: ______________

***Please send a copy of insurance card(s)/Specify if no card is available.**

Primary Insurance: _____________________________ Policy Number: __________________________

Subscriber Name: ______________________________ DOB: _________________________

Secondary Insurance: ___________________________ Policy Number: __________________________

Subscriber Name: ______________________________ DOB: _________________________

Reason for referral: ____

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Patient's eye condition/diagnosis: ____

***Along with this referral form, please send the most recent eye exam, including all pertinent diagnostic tests (i.e. Fields). If records are in a digital format, they may be sent to uc-vision@wmich.edu.**

Upon Receipt of all referral information, the patient will be contacted to schedule an appointment.