Vision Clinic
Western Michigan University-Unified Clinics
1000 Oakland Dr •Kalamazoo, MI 49008
PH: (269) 387-7064/Fax: (269) 387-7227

Referral Form

Date:___/___/___

Referring Physician:_____Phone:_____

Fax:_____ *Urgent? Y / N

Contact Name:_____Phone:_____

Patient Name:_____ Gender: M / F DOB:____/____/_____.

Interpreter required? Y / N ; Which language?_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email:_____ Preferred contact: Home Work Cell

Patient's Address: _____

City:_____ State: _____ Zip_____

Guardian' s name (if patient is a minor): _____DOB___/___/___

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

*Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____ DOB:___/___/___

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*Patient's eye condition/diagnosis:_____

INSTRUCTIONS:
Along with referral form, please send most recent eye exam, including all pertinent diagnostic tests (ie. Fields).

If records are in a digitized format, they may be send via email to: cassandra.motycka@wmich.edu or Fax to above number.

Upon receipt of all referral information, the patient will be contacted to set up an appointment.