



**Verdier  
Eye  
Center**

1000 East Paris Ave SE  
Suite 130 & 150 Grand Rapids, MI 49546  
Phone: (616) 949-2001 Fax: (616) 949-8620

**VerdierEyeCenter.com**

David D. Verdier, M.D.  
Karl J. Siebert, M.D.  
Ann M. Renucci, M.D., F.A.C.S.  
Kyle B. McKey, M.D.  
Roman I. Krivochenitser, M.D.

Troy L. Fox, O.D., F.A.A.O.  
Brittany A. Darnley, O.D.  
Jordan L. Marentette, O.D., F.A.A.O.  
Derek M. Phelps, O.D., F.A.A.O.

## PATIENT REQUEST FOR EVALUATION REFERRAL

**We look forward to working with you to help address your patient's eye health needs.**

**If you're experiencing a medical emergency, please call 911.**

Verdier Eye Center is a referral-based practice. Together, we can deliver exceptional patient care.

To refer a patient, please complete the online referral form below.

**\*Please Fax with Form: Physician Notes/Letter and Diagnostic Tests\***

Failure to fill out the entire form or attach proper information will result in a delay of processing an appointment.

Type of Appt:  Urgent  Routine

Date: \_\_\_\_\_

### Patient Information

Patient Name (*Legal Name*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician (*First and Last Name*): \_\_\_\_\_  MD  OD

Does the patient currently reside in a Skilled Nursing Home, Assisted Living Facility or Group Home?

No  Yes, please indicate the place of residence: \_\_\_\_\_

Is an Interpreter Needed?  No  Yes, language: \_\_\_\_\_

Reason for Referral (diagnosis): \_\_\_\_\_

Referring to:  David D. Verdier, M.D.  Karl J. Siebert, M.D.  Ann M. Renucci, M.D.  Kyle B. McKey, M.D.  Roman I. Krivochenitser, M.D.  
 Troy L. Fox, O.D.  Brittany A. Darnley, O.D.  Jordan L. Marentette, O.D.  Derek M. Phelps, O.D.

### Medical Insurance Information (Attach Copies of Insurance Card(s)):

Primary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_

### Referring Physician Information:

Referring Physician (*First and Last Name*): \_\_\_\_\_  MD  OD NPI#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Person filling out form: \_\_\_\_\_

### OFFICE USE ONLY:

Appointment Date and Time: \_\_\_\_\_

Chart #: \_\_\_\_\_ Initials: \_\_\_\_\_ Date and time faxed back: \_\_\_\_\_