# PATIENT REFERRAL FORM

PHYSICIANS:

- ☐ **Shareef Ahmed, M.D.**
  Vitreoretinal Specialist
  *Dearborn & Madison Heights*
- ☐ **David Ellenberg, M.D.**
  Vitreoretinal Specialist
  *Dearborn & Livonia*
- ☐ **Bianca Kizy, M.D.**
  Comprehensive Ophthalmology
  *Dearborn & Madison Heights*
- ☐ **Nate Kleinfeldt, M.D.**
  Cataract & Glaucoma Surgery
  *Dearborn & Livonia*
- ☐ **Andrew Lofman, M.D.**
  Oculoplastics
  *Livonia*
- ☐ **Zachary Pearce, D.O.**
  Oculoplastic Specialist
  *Dearborn*
- ☐ **Benjamin Reinherz, D.O.**
  Vitreoretinal Specialist
  *Madison Heights*
- ☐ **Stephen Verb, M.D.**
  Glaucoma Disease & Surgery
  Comprehensive Ophthalmology
  *Dearborn & Madison Heights*

LOCATIONS:

- ☐ **Dearborn Office**
  24241 Michigan Avenue
  Dearborn, MI 48124
  **P: (313) 561-7255**
  F: (313) 561-6137
- ☐ **Livonia Office**
  33400 W. Six Mile Road
  Livonia, MI 48152
  **P: (734) 421-2020**
  F: (734) 421-2290
- ☐ **Madison Heights Office**
  301 W. 13 Mile Road
  Madison Heights, MI 48071
  **P: (248) 268-1079**
  F: (248) 268-3980

Date: ____________________

Patient Name: ________________________________ DOB: _______________

Address: ________________________________________________________________

________________________________________________________________

Phone Number: ________________________________________________________

Medical Insurance: ____________________________________________________

## THE PATIENT IS BEING REFERRED FOR EVALUATION OF:

☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ AMD ☐ Other __________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

☐ If cataract surgery is needed, I want to co-manage: ________________________
Referring physician signature required

☐ The patient will call for an appointment.

☐ Please call the patient to arrange an appointment.

☐ The appointment was scheduled for:

Date: ____________________ Time: _______________

Location: ☐ Dearborn ☐ Livonia ☐ Madison Heights

## PLEASE SEND A REPORT TO:

Name: ________________________________________________________________

Address: ________________________________________________________________

________________________________________________________________

Phone Number: ________________________________________________________

Fax Number: ________________________________________________________

For Office Use Only

Attempt #1: ____________________ Attempt #2: ____________________ Attempt #3: ____________________

Notes: ________________________________________________________________