



**WESTERN MICHIGAN UNIVERSITY**  
College of Health and Human Services  
Unified Clinics

**Vision Rehabilitation Clinic**  
Western Michigan University Unified Clinics  
1000 Oakland Drive - 4<sup>th</sup> Floor, Kalamazoo, MI 49008  
Phone: (269) 387-7064 | Fax: (269) 293-3357

**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: \_\_\_\_\_  
\_\_\_\_\_

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](mailto:uc-vision@wmich.edu).**

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