

AKLER EYE CENTER
2841 MONROE STREET SUITE 1
DEARBORN, MI, 48124

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COORDINATING YOUR PATIENT CARE

PLEASE INCLUDE OFFICE NOTES AND INSURANCE INFORMATION WITH ALL REFERRALS.
THE ABSENCE OF REFERRAL NOTES MAY CAUSE A DELAY IN SCHEDULING PATIENTS.

****IF THE PATIENT NEEDS TO BE SEEN WITHIN 24-48 HOURS, PLEASE CALL THE OFFICE DIRECTLY. ALL OTHER NON-URGENT REFERRALS WILL BE CALLED WITHIN 2-3 BUSINESS DAYS.**

Patient Name: _____ D.O.B. _____

Patient Phone: _____

Referring Physician: _____

Primary Care Physician: _____

Optometrist: _____

Phone: _____ Fax: _____

****Insurance Coverage:** _____ **ID#** _____

Subscriber: _____ **Subscriber DOB:** _____

Reason for Consultation (mark all that apply)

- | | |
|---|--|
| ☐ Age-related Macular Degeneration | ☐ Unexplained Vision Loss/Unknown Maculopathy |
| ☐ Cataract Consult | ☐ Thyroid Eye Disease |
| ☐ Cornea | ☐ Refractive Surgery |
| ☐ Diabetic Retinopathy | ☐ Glaucoma |
| ☐ Epiretinal Membrane | ☐ Lid Conditions |
| ☐ Macular Hole | ☐ Other: _____ |
| ☐ Retinal Tear/Detachment (please call office) | |

****Time frame in which the patient should be seen (please circle):**

24-48 hrs.(call us) ☒ 1 week ☐ 2 weeks ☐ 1 month ☐ Next available Other: _____

Additional Comments: _____
