

**EYE PLASTIC & FACIAL RECONSTRUCTIVE SURGERY REFERRAL FORM**

**Dr. Adam S. Hassan & Dr. Jasmina Bajric**

**TO SIMPLIFY AND STREAMLINE THE REFERRAL PROCESS PLEASE COMPLETE THE FORM IN IT'S ENTIRETY**

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell \_\_\_\_ - \_\_\_\_ - \_\_\_\_

PRIMARY MEDICAL INSURANCE CARRIER: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_

SECONDARY POLICY IF APPLICABLE: \_\_\_\_\_

- Workman's Comp: YES / NO
- Auto Insurance: YES / NO

Claim Adjuster: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Claim #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**REASON FOR REFERRAL:**

- Orbital     Orbital Fracture     Graves Disease     Lid Eval     BCC     SCC

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

**PLEASE INCLUDE ANY RELEVANT CLINICAL NOTES, SCANS, LABS, OR VISUAL FIELD TESTING**

URGENT     7-14 DAYS     NEXT AVAILABLE

Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

PCP Name: \_\_\_\_\_ Phone: \_\_\_\_\_

PCP Address: \_\_\_\_\_ Fax: \_\_\_\_\_

*Member of the American Society of Ophthalmic Plastic & Reconstructive Surgery*

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