MID MICHIGAN RETINA

ASHIM AGGARWAL, M.D.
BOARD CERTIFIED
AMERICAN BOARD OF
OPHTHALMOLOGY

Please fax this completed form to 517-574-5852

MMR Staff ONLY
Appt Date: _____
Appt Time: _____

PATIENT REFERRAL FORM

APPOINTMENT INFORMATION

_____
DATE OF REQUEST (MM/DD/YYYY)

Referral Location (Check One):
☐ 1070 Trowbridge Rd., East Lansing, MI 48823
☐ 905 E. Pickard St., Mt. Pleasant, MI 48858
☐ 14915 W. Michigan Ave., Marshall, MI 49068

PATIENT INFORMATION

☐ MALE ☐ FEMALE

NAME (First/Last) _____ DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ INSURED ID _____ POLICY GROUP _____

SECONDARY INSURANCE _____ INSURED ID _____ POLICY GROUP _____

REFFERING PHYSICIAN INFORMATION

REFERRING PHYSICIAN'S NAME (FIRST/LAST) _____ PHONE NUMBER _____ FAX NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN'S NAME (First/Last) _____ PRIMARY CARE PHYSICIAN'S PHONE NUMBER _____

REASON FOR REFERRAL (please attach relevant reports including current medication list)

SIGNATURE OF REFERRING PHYSICIAN _____ DATE _____