REFERRAL FORM

NORTHWEST EYE CARE PROFESSIONALS

FAX TO: (503) 657-7066

PATIENT NAME: TODAY'S DATE:

DATE OF BIRTH: DATE OF LAST SERVICE:

PATIENT CONTACT INFO

PREFERRED PHONE: H ○ C ○

ADDRESS:

MEDICAL INSURANCE CARRIER:

REFERRING PROVIDER INFO

PROVIDER/SPECIALTY:

CLINIC NAME:

PHONE: FAX:

EMAIL:

REASON FOR REFERRAL (E.G. REHAB/TBI, DEVELOPMENTAL, DIABETIC, ETC.):

ADDITIONAL INFO/REQUESTS (ATTACH RECORDS IF POSSIBLE):

○ DEMOGRAPHICS ATTACHED (REQUIRED FOR SCHEDULING)

PREFERRED CLINIC?

○ **CLACKAMAS**
15259 SE 82nd Dr, #101
(near Clackamas Town Center)
P: (503) 657-0321

○ **VANCOUVER**
1401 SE 164th Ave, #100
(east Vancouver)
P: (360) 546-2046

○ **BEAVERTON**
10970 SW Barnes Rd
(near Cedar Hills)
P: (503) 214-1396

○ **HILLSBORO**
5880 NE Cornell Rd, Ste. B
(Orenco Station)
P: (503) 905-2828

NWECP IS...

Bruce Wojcieshowski, OD, FCOVD
John Reski, OD, FCOVD
Macson Lee, OD, FCOVD
Rachel Jorgensen, OD, FCOVD
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