L|O|EYE CARE

Mikey's Fund Eye Care Referral

Date: _____

School/Organization Name: _____

Phone Number: _____ Ext: _____

Does the patient meet the criteria below? Yes _____ No _____

If yes, which ones:

- ☐ Is a current student of a Michigan Public School
- ☐ Has a medical need for eye care services
- ☐ Has insurance but the insurance will not pay for the entire service
- ☐ Has no medical insurance
- ☐ Has no vision insurance
- ☐ Income is at the poverty level or below poverty level
- ☐ The referring school or organization staff member determines that the patient is not able to afford the service

Please explain: _____

_____

_____

Patient information:

First Name: _____ Last Name: _____

Address: _____

Phone #: _____ Date of Birth: _____

Insurance type if applicable: _____

Parent/Guardian's Name: _____

Service(s) Requested: (Please Circle)

Eye Exam New Glasses Repairing Glasses

Does the patient need assistance with transportation? (only applicable in Lansing)

_____ Yes (if yes, please have patient's guardian complete the information below)

Name of parent/guardian: _____

Parent/guardian's signature: _____

By signing this form, you are giving L.O. Eye Care permission to share this form with The Davies Project. A representative of The Davies Project will contact you regarding your interest in receiving rides to a L.O. Eye Care office for appointments.

Nurse/School Staff member: _____

Date: _____

Please fax to: 517.324.7188 Attn: Danielle Skinner, Patient Relations