LOW VISION REFERRAL/CONSULTATION FORM

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Please complete the form as best you can. **PLEASE PRINT**.

Patient's name: _____ Date of birth: _____ Sex: M / F

Address: _____
Street City State Zip code

Phone: (_____)_____ Cell phone: (_____)_____

History & Referral Information:

Eye Condition: _____

Visual acuities (without correction): OD: _____ OS: _____
(with correction): OD: _____ OS: _____

Glasses/contacts: ☐ YES ☐ NO If so: ☐ NEAR ☐ DISTANCE ☐ PROTECTION
☐ FULL-TIME WEAR

Date of last eye exam: _____

Low Vision Concerns:

Has the patient had a low vision exam before? ☐ YES ☐ NO
If yes, date of last exam: _____

Has there been a recent change in vision? ☐ YES ☐ NO
If yes, please explain: _____

Did, or does the patient use? ☐ Magnifier(s) ☐ Monocular ☐ CCTV

Comments: _____
_____

What is your specific concern about the patient's vision loss? _____
_____

What one or two activities would the patient like to make visually easier? _____
_____

Referring doctor's name: _____ **NPI #:**_____ **Date:** _____

Referring office info: _____(____)_____(_____)_____
Address Phone Fax

Please fax over any other pertinent information that may help (e.g. previous exams, reports, etc.) to (858) 560-1926.