

Consultation Request

Name: _____ Phone: _____

Address: _____ D.O.B.: _____

_____ S.S.#: _____

Insurance Primary: _____ ID# _____

Insurance Secondary: _____ ID# _____

Additional Patient Information:

Contact person: _____

Phone#: _____

Referral Information:

Referred by:

Primary Care Physician: _____

Optometrist: _____

Ophthalmologist: _____

Current Acuity (BVA):

Current Glasses RX:

OD 20/

OD

OS 20/

OS

Diagnosis: OD _____

Stable/Uncertain

OS _____

Stable/Uncertain

Date of Last Exam:

I am referring this patient for Low Vision Consultation and Treatment.

Signature of Referring Doctor: _____ Date: _____

Please fax any pertinent treatment documentation for patient including visual field.

Appointment Time: _____