OD/MD Patient Referral Form

For Low Vision and/or Blind Rehabilitation Services 2/16

Client Name _____ **Date of Referral**_____

Address_____**City**_____**State**_____**Zip**_____

Phone _____ **DOB**_____

Alternative Contact _____ **Phone**_____

Primary Insurance Name _____**Primary Insurance ID #** _____

Secondary Insurance Name _____**Secondary Insurance ID #** _____

Is patient in a Skilled Nursing Facility or Receiving Home Healthcare? Yes/No

If yes, please list the contact number _____

Primary Care Physician_____ **Practice Phone**_____

Primary Eye Doctor_____ **Practice Location & Phone**_____

Date of Last Visit _____ **Diagnosis: OD** _____ **OS**_____

Best Corrected VA Distance OD_____ **OS**_____ **Near OD**_____ **OS**_____

Status (please circle one) Stable *or* Slowly Progressive *or* Deteriorating

Visual Field Loss: Yes/No *If yes, please provide a copy of the most recent visual field report to be used for mobility assessment/recommendations.*

Significant co-existing ocular or systemic pathology (such as diabetes)? _____

Retina Specialist _____ **Practice Phone** _____

Referring Practice Name _____ **Referring Dr. *Signature***_____

Address_____ **Referring Dr. *Printed Name***_____

City _____**State** _____**Zip**_____

Phone _____

A full examination report would be appreciated and will greatly assist The Sight Center in providing the best service to this patient. Thank you!

Please Fax, E-Mail or Mail this Referral Form. We will contact the consumer to schedule services.

The Sight Center of Northwest Ohio
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Mission:
We empower independence & enrich the lives of people who are blind or visually impaired.
We don't change vision. We change lives.