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7/2024

Patient Referral Form

Low Vision and/or Blind Rehabilitation Services

Please send full examination report to assist The Sight Center in providing the best low vision rehabilitation service to your patient. Complete the following form with any information not included in the examination report. Thank you!

Patient

Last Name _____ First Name _____ DOB _____

Address _____ City/State/Zip _____

Phone # _____ Alt. Contact # _____

Medical Insurance _____ ID # _____

Secondary Insurance _____ ID # _____

Referring Doctor

Doctor Name _____ Phone # _____ Fax # _____

Practice Name/Location _____

Ocular Examination

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 (please circle one): No / Yes - *If yes, please provide a copy of the most recent visual field report to be used for mobility assessment/recommendations.*

Is this person legally blind (please circle one): No / Yes

Significant co-existing ocular or systemic pathology (such as diabetes) that our team should be aware of?

Refer by Fax 419-720-3938 or Online at www.VisionRefer.org.



We don't change vision. We change lives!

