The Sight Center of northwest ohio

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5/2025

Patient Referral Form

Low Vision/ Blindness Rehabilitation Services

Please send full exam 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.

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 | Email referrals@sightcenternwo.org | Online www.visionrefer.org

Our staff will contact your patient to initiate services. Thank you!

We don't change vision. We change lives!

AER