Referral Form

Patient's name ____

Address____ City/Zip_________________________

Phone __________________________________ Date of Birth ____

Primary Medical Insurance Policy ____

Diagnosis/Cause of Vision Loss ____

Best Corrected Visual Acuity: OD _________ OS _________

A low vision evaluation is being requested because patient is having difficulty with the following:

__ Near Tasks (reading print, mail, managing finances, etc.)

__ Distance Tasks (driving, seeing faces, watching television, etc.)

__ Photophobia (difficulty with glare or visual discomfort)

__ Mobility (constricted visual field)

__ Vocational (maintaining or finding work)

__ Other____

Referring Clinic Information

Referring Doctor's Name ____

Clinic name____

Address ____

Phone ____Fax____

Clinic direct e-mail for correspondence ____

Please return completed form and a copy of the patient's most recent eye exam by fax, mail or email to info@viewfinderlowvision.com

Mesa	**Sun City**
1830 S. Alma School Rd. #131	**10001 W Bell Rd. #115**
Mesa, AZ 85210	**Sun City, AZ 85351**
Phone: 480-924-8755	**Phone: 623-583-2800**
Fax: 480-854-1864	**Fax: 623-583-1556**