**Referral for Low Vision Clinic Services**

Referral Date: Click or tap to enter a date. Patient Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date. Phone Number: Click or tap here to enter text.

Gender Given at Birth:  Male  Female Other Info: Click or tap here to enter text.

Address: Click or tap here to enter text. City, State, Zip: Click or tap here to enter text.

Contact Person: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

(if other than the patient)

Diagnosis (check all that apply):

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| --- | --- |
| Albinism, Oculocutaneous | Glaucoma, Primary Open Angle |
| Aniridia | Homonymous Hemianopia |
| Cataract, Congenital | Macular Degeneration, Age Related |
| Cataract, Cortical | Macular Degeneration, Dry |
| Cataract, Nuclear | Macular Degeneration, Wet |
| Cataract, Posterior Subcapsular | Nystagmus, Congenital |
| Central Scotoma | Optic Nerve Hypoplasia |
| Cone Dystrophy, Progressive | Retinal Detachment, Old, Partial |
| Cortical Visual Impairment | Retinal Dyst., Hered. usp (Leber’s, etc.) |
| Diabetic Macular Edema | Retinal Dyst., Hered. RP |
| Diabetic Retinopathy, Non-Proliferative | Retinitis Pigmentosa |
| Diabetic Retinopathy, Proliferative | Retinopathy of Prematurity |
| Generalized Visual Field Restriction | Other |

Visual Acuities with Best Correction: Right: Click or tap here to enter text. Left: Click or tap here to enter text.

Visual Fields:  Peripherally Full  Restricted  Central Scotoma  Other

Special Visual Considerations: Click or tap here to enter text.

General Health Considerations: Click or tap here to enter text.

Date of last vision exam: Click or tap to enter a date.

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| Click or tap here to enter text. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Printed Name of Clinician | Clinician Signature |