**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):

|  |  |
| --- | --- |
| [ ]  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 |