Eye Care Provider Referral Form

Date: ________________
Refringing Doctor: ___________________________ Phone: ___________________________
Office: ___________________________ Fax: ___________________________
Address: ___________________________ Email: ___________________________

Client name: ___________________________ Gender: M F Other DOB: ________
Mailing address: ___________________________
Physical address (if different): ___________________________
Primary phone: ___________________________ Other phone: ___________________________

Reason for referral:

Degree of visual impairment: ☐ Totally blind ☐ Severe visual impairment
☐ Legally blind (see below) ☐ Moderate impairment
☐ Check here if legally blind because of visual field, not acuities

Cause of vision loss: ☐ Accidental ☐ Glaucoma ☐ Retinitis Pigmentosa
☐ Cataracts ☐ Stroke ☐ Macular Degeneration
☐ Detached Retina ☐ Myopia ☐ Optic Atrophy
☐ Diabetic Retinopathy ☐ Unknown
☐ Other (explain)

Date of last exam: ________________

Prognosis:
1. ___________________________ Stable: _____ Progressive: _____
2. ___________________________ Stable: _____ Progressive: _____

Visual Acuities: R.E. L.E. Example
Distant with best correction __________ __________ 20/20
Near with best correction __________ __________ 1M @ 10”

Degrees of Visual Field: R.E. L.E.

Surgical/Medical History:

Treatment Plan:

Meets VT driving requirements? ☐ Yes ☐ No

Legal blindness, as defined by the SSA, is when CORRECTED vision in your BEST eye is worse than 20/100.
People with average acuity who have a visual field of 20 degrees or less are also classified as being legally blind.

Doctor’s signature ___________________________
Additional Notes