Eye Care Provider Referral Form

Date: _______________
Referring 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 □ Legally blind (see below) □ Severe visual impairment □ No information available

□ 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 □ Other □ Unknown

Date of last exam: _______________

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

Near without correction ___________________________ ___________________________ ___________________________
Near with correction ___________________________ ___________________________ ___________________________
Distant without correction ___________________________ ___________________________ ___________________________
Distant with correction ___________________________ ___________________________ ___________________________

Degrees of Visual Field: ___________________________

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