Low Vision Referral Form

Type of vision care requested:

- ☐ Consult and render opinion only
- ☐ Low vision evaluation and treatment
- ☐ Low vision Occupational Therapy evaluation and treatment only
- ☐ In-home safety evaluation
- ☐ Other:_____

Patient Name:_____ DOB:_____

Diagnosis:_____ Code (optional):_____

Spouse/Caregiver Name:_____

Patient's Address:_____

City:_____ State:_____ Zip:_____

Phone: _____

Referring Professional: _____

Referring Office: _____

Contact Phone: _____

Check all conditions that apply or are in question:

- ☐ Decreased distance acuity
- ☐ Difficulty with reading
- ☐ Known V.F. loss or restrictions
- ☐ Photophobia or glare problems
- ☐ Diplopia or ghost images
- ☐ Objects "jump" into or out of field of vision
- ☐ Light sensitivity
- ☐ Trouble seeing contrast
- ☐ Other_____
- ☐ _____
- ☐ _____
- ☐ _____

Additional information:

_____

_____

_____ _____

Doctor (signature) **Date**

Please fax this form, the patient's contact information, and current vision records to (913) 469-8688.

We will contact the patient to schedule and prepare them to visit our office. If you have questions, please call (913) 469-8686. Thank you for allowing Dr. Metzger and his team to share in your patient's vision care. A report will be sent to your office at the completion of services.