



**REFERRAL FORM**

**\*\*PLEASE INCLUDE A COPY OF YOUR LATEST EYE EXAMINATION REPORT\*\***

**DEMOGRAPHIC INFORMATION**

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ M/F \_\_\_\_\_  
 Patient's Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy Number \_\_\_\_\_

**VISION INFORMATION**

Distance Acuity OD: \_\_\_\_\_ OS \_\_\_\_\_ Near Acuity OD: \_\_\_\_\_ OS \_\_\_\_\_  
 Visual Field Deficits: If so, please note: OD \_\_\_\_\_ OS \_\_\_\_\_  
 Scotoma:  OD  OS Does this patient meet requirements to be legally blind?  No  Yes If yes, date of onset: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_  
 Comments or Special Instructions: \_\_\_\_\_  
 Date of this examination: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of next appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SIGNATURE AND CONTACT INFORMATION**

Doctor's Signature: \_\_\_\_\_ Please Print Name \_\_\_\_\_  
 This referral is for evaluation and treatment.  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*COMPLETE THE SECTION BELOW ONLY IF YOU ARE NOT INCLUDING A COPY OF YOUR LATEST EXAMINATION REPORT\*\***

Please list ALL medications, or attach a copy of medication list: \_\_\_\_\_  
 \_\_\_\_\_

Past ocular procedures and dates, if known: Cataract extraction  No  Yes :  OD  OS  
 Laser Tx  No  Yes :  OD (Check reason)  OS (Check reason)  
 Injections  No  Yes :  OD  OS  
 Nd:YAG  Nd:YAG  
 Tx for diabetic retinopathy  Tx for diabetic retinopathy  
 Tx for macular degeneration  Tx for macular degeneration  
 Tx for glaucoma  Tx for glaucoma  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Prognosis: Stable? \_\_\_\_\_ Progressing slowly? \_\_\_\_\_ Progressing rapidly? \_\_\_\_\_ Unknown? \_\_\_\_\_

Family History: \_\_\_\_\_

Date of refraction: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Eyeglass Rx:

	Sphere	Cylinder	Axis	Add
OD				
OS				