**FUTURE IN SIGHT • 25 Walker Street • Concord, NH 03301**
**(603) 224-4039 • Fax (603) 224-4378**

# 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:_____

ICD-10 Diagnosis Codes:_____

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 | | | | |