



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 _____

City _____ State _____ Zip _____

Phone _____

Primary Insurance _____ Subscriber _____ Policy Number _____

Secondary Insurance _____ Subscriber _____ Policy Number _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

VISION INFORMATION

Distance Acuity: OD _____ OS _____ Near Acuity: OD _____ OS _____

Visual Field Deficits: OD _____ OS _____

Scotoma: OD OS

Does this patient meet requirements to be legally blind? YES NO If yes, date of onset: _____

Diagnosis: _____

ICD-10 Diagnosis Codes: _____

Date of this examination: _____ Date of next appointment: _____

SIGNATURE AND CONTACT INFORMATION

Physician or Optometrist Signature: _____

This referral is for evaluation and treatment.

Please Print Name _____

Address: _____ Phone: _____ Fax: _____

PLEASE INCLUDE A COPY OF YOUR LATEST EXAMINATION REPORT**

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