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_____

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

Doctor's Signature:_____ Please Print Name_____

This referral is for evaluation and treatment.

Address: _____ Phone: _____ Fax: _____

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

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

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