LIGHTHOUSE GUILD
Vision+Health

REFERRAL TO LIGHTHOUSE GUILD FOR LOW VISION REHABILITATION SERVICES

Please evaluate my patient (name) _____ for low vision services.

Patient Information

Date of Birth: _____ Telephone: _____

Address: _____ City/State/Zip: _____

If language other than English, please specify: _____

Visual Acuity: OD _____ OS _____

Visual Field: _____ 20 degrees or less? OD ◯ yes ◯ no OS ◯ yes ◯ no

If visual field 20 degrees or less, please provide a copy of the latest results

Vision diagnosis: _____

Secondary diagnosis, current eye medications, and surgical history: _____

_____

Is the patient legally blind? ◯ yes ◯ no

Functional difficulties due to vision loss

- ☐ reading, writing
- ☐ household activities
- ☐ using cell phones or other technology
- ☐ identifying medications
- ☐ getting/keeping a job
- ☐ moving around safely (falls)
- ☐ feeling nervous, anxious or on edge
- ☐ feeling down, depressed or hopeless

Physician Information

Physician's name: _____

Physician's signature: _____

Business Address: _____ City/State/Zip: _____

Telephone: _____ Fax: _____ Email: _____

Please return to Lighthouse Guild

250 West 64th Street, New York, NY 10023
Jocelyn A. Tapia. Fax 212-769-7825. Email TapiaJ@lighthouseguild.org

Patient Signature

I understand that a copy of this form will be faxed to Lighthouse Guild and that a representative may contact me or my practitioner to facilitate this referral. All information will be kept confidential.

Signature: _____ Date: _____

THIS FORM CAN ALSO BE COMPLETED AND PRINTED AT: lighthouseguild.org/referral.pdf