



## 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      \_\_\_ identifying medications

\_\_\_ household activities      \_\_\_ getting/keeping a job

\_\_\_ using cell phones or other technology

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 64<sup>th</sup> Street, New York, NY 10023**

Jocelyn A. Tapia. Fax 212-769-7825. Email [TapiaJ@lighthouseguild.org](mailto: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](http://lighthouseguild.org/referral.pdf)

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