



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

Eye diagnosis: _____

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

Is the patient legally blind? yes no If legally blind, please add social security number _____

Insurance provider: Medicare Medicaid Other (specify) _____ ID number: _____

Functional difficulties due to vision loss

reading, writing

identifying medications

moving around safely (falls)

household activities

getting/keeping a job

feeling nervous, anxious or on edge

using cell phones or other technology

feeling down, depressed or hopeless

Physician Information

Physician's name: _____ NPI# _____ Specialty: _____

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

Lighthouse Guild • 250 West 64th Street, New York, NY 10023 • 800-284-4422 • lighthouseguild.org