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LOW VISION REFERRAL

Patient Name: _____

Date: _____

Date of Birth: _____

Telephone: _____

Diagnosis

- | | |
|--|---|
| <input type="radio"/> Macular Degeneration (AMD) | <input type="radio"/> Retinitis Pigmentosa |
| <input type="radio"/> Glaucoma | <input type="radio"/> Optic Atrophy |
| <input type="radio"/> Diabetic Retinopathy | <input type="radio"/> Best Disease |
| <input type="radio"/> Stargardt Disease | <input type="radio"/> Adult Vitelliform Dystrophy |
| <input type="radio"/> Pathological Myopia | <input type="radio"/> Mac Tel 2 |
| <input type="radio"/> Macular Hole | <input type="radio"/> Albinism |
| <input type="radio"/> Cataract | <input type="radio"/> Toxic Maculopathy |
| <input type="radio"/> Other _____ | <input type="radio"/> Hemianopsia |

Additional Notes

Referring Doctor: _____

Telephone: _____

Fax: _____

Please fax this form,
 along with a copy of the patient's
 most recent exam notes, to
(619)362-9895

IF YOU RECEIVE THIS FORM IN ERROR, PLEASE CONTACT THE SENDER IMMEDIATELY AND THEN DESTROY THE FAXED MATERIALS.

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