LOW VISION REFERRAL FORM

YESNICK LOW VISION CENTER

9191 W. Flamingo Rd. ~ Las Vegas, NV 89147
(702) 966-2020 (Fax) 966-2022 (email) Sandy@TheYVC.com

REFERRING DOCTOR INFO: Please fax/email **completed referral form with VA's, Diagnoses, Doctor's signature** and **copy of Insurance Card(s).**

PATIENT NAME: _____ **DOB:** _____ **TEL;** _____

ADDRESS: _____ **ZIP:** _____ **INSURANCE:** _____

PROCEDURE REQUESTED	RETINA	DIABETES	LENS
_____Low Vision EVAL & REHAB	____AMD NOS	____DR NOS	____Cataract OD
_____Low Vision EVAL ONLY	____AMD Dry	____DR Proliferative	____Cataract OS
_____Implantable Mini Tele (IMT) EVAL	____AMD Wet	____HTN Retinopathy	____Cataracts OU
	____Mac Hole	____DM I/ IDDM	
Date of Last Eye Exam _____	____Mac Scar	____DM II/NIDDM	
VA: NEAR or DISTANT		____DM w/o Retinopathy	
OD:_____	____Ret Dystrophy		
OS:_____	____Ret Edema		
OU:_____	____Retinitis Pigmentosa		

GLAUCOMA	CVA/NEURO	OTHER	
____Chronic angle Glaucoma NOS	____CVA related	____Dry Eye Syndrome	____Other DX: _____
____POAG	____Hemianopsia	____Optic atrophy NS	____ Other DX: _____
____Angle Closure	____VF Defect	____ Lack of Coordination	____ LOW VISION DEVICES
____Glaucoma NOS disorder		____ Post Vit. Sep	(attach description)

X _____ _____

DOCTOR SIGNATURE **DATE** **DOCTOR'S NAME**

Doctor's NPI Number _____ (please include for electronic billing purposes)

Email:_____Phone: _____Fax:_____