REFERRAL FORM

VISION RECOVERY CENTER

9191 W. Flamingo Rd. ~ Las Vegas, NV 89147
(702) 966-2020 (Fax) 966-2022 ~ 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
______Low Vision EVAL & REHAB
______Low Vision EVAL ONLY
______Implantable Mini Tele (IMT) EVAL

Date of Last Eye Exam ___________
VA: NEAR or DISTANT
OD:_________________
OS:_________________
OU:_________________

RETINA
____AMD NOS
____AMD Dry
____AMD Wet

____Mac Hole
____Mac Scar

____Ret Dystrophy
____Ret Edema
____Retinitis Pigmentosa

DIABETES
____DR NOS
____DR Proliferative
____HTN Retinopathy

____DM I/ IDDM
____DM II/NIDDM
____DM w/o Retinopathy

LENS
____Cataract OD
____Cataract OS
____Cataracts OU

GLAUCOMA
____Chronic angle Glaucoma NOS
____POAG
____Angle Closure
____Glaucoma NOS disorder

CVA/NEURO
____CVA related
____Hemianopsia
____VF Defect

OTHER
____Dry Eye Syndrome
____Optic atrophy NS
____ Lack of Coordination
____ Post Vit. Sep

____Other DX: __________________
____ Other DX: __________________
____ LOW VISION DEVICES
(attach description)

X

DOCTOR SIGNATURE _______________ **DATE** ________________________ **DOCTOR'S NAME**

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

Email:_______________________________________ **Phone:** __________________ **Fax:**_________________________