Vision Recovery Center
9191 W. Flamingo Rd.
Las Vegas, NV 89147
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Vision Recovery Center
Support Vision, Give Sight

Low Vision or Scleral Contact Lens Referral

Patient Name _____ DOB _____

Address _____ City/Zip_____

Phone _____ Contact (in case of emergency) _____

Insurance: NO / YES _____

Diagnoses Associated with Vision Loss or Scleral/Specialty Contact Lens:
_____

Best Corrected Visual Acuity: OD _____ OS _____

Scleral or Specialty Lens goals: _____ * Include Topo and/or OCT

Reduction in Visual Field? ☐ Yes ☐ No If yes, please send the last VF.

A low vision or specialty contact lens consultation has been requested because the patient is having difficulty with the following tasks:

____ Distance Vision (seeing loved one's faces, TV, stop lights)

____ Near Tasks (Reading printed menu, newspaper, Cell Phone or medicine bottle)

____ Intermediate Tasks (Navigator, crafts, computer)

____ Mobility/Driving (safe walking, h/o tripping or falling)

____ Photophobia (indoor and outdoor glare)

Referring Doctor _____ of _____

Email (Provide Feedback) _____ Cell_____ F_____

Names of the other eye care specialists the patient is currently seeing:
_____

* Please fax over the most recent records, including last visual field or topography/OCT.