LOW VISION OF MICHIGAN

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FAX REFERRAL FORM

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Caregiver/Hospital/Agency

Address

City State Zip

Area Code Phone Best time to call

Reason(s) for Referral:

☐ AMD ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Cataract/ Pseudophakia
☐ Other:_____

Results of Examination

BVA: OD_____ OS_____ Refraction: OD_____ OS_____

Visual Field: WNL Defects _____

Other Pertinent Results of Examination: _____

General Patient Guidelines

20/40 – 20/60: **Mild Vision Loss** – Most activities can be improved.
20/70 – 20/160: **Moderate Vision Loss** – Nearly all people are able to read large print, see faces and t.v. better. Many are able to continue limited driving; some are able to read standard print.
20/200 – 20/400: **Severe Vision Loss** – Most are able to see t.v., faces and photographs. Reading large print is possible.

I hereby grant permission for Low Vision of Michigan at Suburban Eye Care, P.C. and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Suburban Eye Care, P.C. so that their office can contact me (or an appointed representative) to schedule an evaluation.

Patient Signature Date Signature (Doctor)

A copy of all tests results and a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary care and eyeglass prescriptions.