SCHOMBERG
EYE CARE

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LOW VISION ASSESSMENT REFERRAL FORM

Patient name:	Patient's DOB (dd/mm/yy):	Patient phone number:
Patient email:		Parent/ Guardian (if applicable):
Patient address:		
Patient's chief complaint:		
Existing eye condition(s) and ocular history:		
Date of most recent eye examination:	Next scheduled follow up:	
Most recent prescription: OD: OS: Add: Prism:	Best corrected visual acuity: OD: OS: OU:	
Additional information:		

Referring doctor's name:

Referring doctor's address and contact information:

Doctor's signature_____ Date_____

Thank you for your referral. Please complete this form and return to Schomberg Eye Care via email: **schomberg.eyecare@gmail.com** or fax: **1-866-836-3167**