University Eye Center

Vision Rehabilitation Service Referral Form

Patient Name ____ Date of Birth ________________

Patient Email __________________________ Phone (H) _________(W)__________(C)__________

Patient Street Address____

City_________________________________ State_________ Zip Code____________

Office Name _____________________________ Referring Physician ________________________

Office Phone Number ___________________________ Fax _______________________________

Would you like us to call to schedule your patient? □ **Yes** □ **No**

***If the patient has already been scheduled for an appointment, please indicate the date and time:
Date: _________ Time: _________

Diagnosis/ICD-9: ______________ Interpretation of results: □ **Your Office** □ **MCO**

Cause of Vision Loss	**Date of Onset**
O.D.______________________________	O.D.______________________________
O.S.______________________________	O.S.______________________________

All other diagnoses or co-morbidities affecting function

O.D.____

O.S.____

Treatment/s

O.D.____

O.S.____

Prognosis

O.D.____

O.S.____

Best Corrected Visual Acuity

Near: O.D.______________________ Distance: O.D.______________________

O.S.______________________ O.S.______________________

FERRIS STATE UNIVERSITY
University Eye Center

Visual Field

O.D.____

O.S.____

Date of last eye examination: ___________________________

Referring For (please check all that apply)

	Vision Rehabilitation Evaluation and Treatment
	Bioptic Telescope Driving Evaluation
	Neuro-Optometric Rehabilitation Evaluation
	Legal Driving Determination
	Legal Blindness Determination
	Visual Field and Interpretation
	Visual Field Without Interpretation
	Other: Please note

Comments

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Name of Examiner (Print) Signature of Examiner Date