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Low Vision Clinic Exam Referral Form

Requested Referral Information:

Patient Demographics:

Name: _____ DOB: _____

Phone number: _____ ☐ Demographics pages included

Patient Diagnosis:

- | | |
|--|---|
| ☐ Macular Degeneration | ☐ Cataract |
| ☐ Glaucoma | ☐ Stargardt Disease |
| ☐ Diabetic Retinopathy | ☐ Juvenile Macular Disorders |
| ☐ Macular Hole | ☐ Albinism |
| ☐ Pathological Myopia | ☐ Nystagmus |
| ☐ Optic Atrophy | ☐ Corneal Disorders _____ |
| ☐ Hemianopsia - Vision Loss
After a Stroke or Brain Injury | ☐ Other: _____ |

Chart Notes: ****This referral requires doctor's chart notes no older than 12 months***
Kindly FAX most recent chart notes to our office @ 858-381-3414

Referring doctor's information:

Name: _____ Fax: _____

Thank you for referring your patient to our Low Vision Clinic!

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