IMPACT VISION CARE OPTOMETRY

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Rancho Santa Fe, CA 92067-2644
Phone: 858-381-3123 Fax: 858-381-3414

Low Vision Clinic Exam Referral Form

Requested Referral Information:

Patient Demographics:

Name: _____ **DOB:** _____

Phone number: _____ ☐ Demographics pages included

Patient Diagnosis:

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