

Please evaluate my patient _____
for vision rehabilitation services.

Patient information

Telephone _____

Address _____

City/State/Zip _____

Date of birth _____

Visual acuity: OD _____ OS _____

Diagnosis _____

Secondary diagnosis, current eye medications and surgical history we should be aware of

Functional difficulties due to vision loss (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Reading, writing | <input type="checkbox"/> Household activities |
| <input type="checkbox"/> Identifying medications | <input type="checkbox"/> Getting/keeping a job |
| <input type="checkbox"/> Moving around safely (falling) | <input type="checkbox"/> Feelings of sadness |

Physician's name (please print) _____

Physician's signature _____ Date _____

Business address _____

City/State/Zip _____

Telephone _____ Fax _____

E-mail _____

**Please return to: Lighthouse International, 111 East 59th Street, New York, NY 10022-1202;
Attn: Low Vision Services or Fax to: (212) 821-9710**

For patient signature below:

I understand that a copy of this form will be sent via fax to Lighthouse International and that a Lighthouse representative may contact me.
All information will be kept confidential.

Please sign here _____

Date _____

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