Low Vision Rehabilitation Services

Patient Referral Form

☐ Low Vision Optometrist ☐ Occupational Therapist evaluation and treatment

To the doctor: Please complete and fax with recent chart notes to the Low Vision Clinic.

_____ _____
Patient's First Name Patient's Last Name

_____ _____ _____
Address City Zip

_____
Date of Birth _____ / _____ / _____ Email Address

_____ _____
Home Phone Cell Phone

Corrected Distance Acuity		
Corrected Near Acuity		
Current Prescription		
Near Add		
IOL (please circle one)	Yes No	Yes No
Is visual field reduced to 20" or less?	Yes No	Yes No

Diagnosis: _____ ICD-10 Code: _____

☐ I certify that the name above is legally blind. Date of Last Exam: _____

Additional Information: _____

_____

PLEASE INCLUDE INSURANCE INFORMATION:

_____ _____
Primary Secondary

_____
Doctor's Name CIRCLE ONE: OPHTHALMOLOGIST | OPTOMETRIST | PHYSICIAN

_____ _____ _____
Address City Zip

_____ _____
Office Phone Fax Phone

_____ _____
Group/Affiliation Name Email Address

_____ _____
Doctor's Signature Date

LOW VISION CLINIC
(619) 255-9741
fax (619) 286-3038
lvc@sdcb.org

LOCATIONS

San Diego Center
5922 El Cajon Blvd
San Diego, CA 92115
(619) 583-1542

Vista Center
1385 Bonair Road
Vista, CA 92084
(760) 758-5956

Note: Both visually impaired and blind individuals can receive services from San Diego Center for the Blind.