Referral for Low Vision Rehabilitation Services

Referral For:

☐ Low Vision Optometrist ☐ Vision Rehabilitation Program

To the doctor: Please complete the referral form, attach chart notes or reports from eye exams (within the past year) and **FAX TO: 619-286-3038**.

Patient's Name (First/Last): _____

Date of Birth: _____ Primary Language: _____

Street Address:_____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Diagnosis/ ICD-10 code (s):

_____

Visual Acuity: OD _____ OS_____

Ocular/surgical history:_____

Spectacle Rx: OD_____ Add: _____

OS_____ Add: _____

Primary Insurance:_____ Secondary Insurance:_____

Referring Doctor's Name: _____

Signature: _____ Date: _____

Office Address: _____

City/State/Zip Code: _____

Office Phone: _____ Fax: _____

SAN DIEGO CENTER FOR THE BLIND

SAN DIEGO CENTER
5922 El Cajon Boulevard
San Diego, CA 92115

VISTA CENTER
1385 Bonair Road
Vista, CA 92084

Low Vision Services: (619) 255-9741
Fax: (619) 286-3038
email: lvc@sdcb.org