# REFERRAL FORM

****IF POSSIBLE, PLEASE INCLUDE A COPY OF PATIENT'S LATEST EYE REPORT****

## DEMOGRAPHIC INFORMATION

Patient's Name: ____________________________________________ DOB: _____________________

Patient's Address: ____________________________________ Phone: ___________________________

Primary Insurance: ________________________ Male/Female: __________________________________

## VISION INFORMATION

Diagnosis: _____________________________ ICD-10 Diagnosis Codes: ______________________________

Distance Acuity OD: ____________ OS: _____________ Near Acuity OD: ____________ OS: ________________

Degree of usable Visual Field: OD _________________ OS ________________ Date of Exam: _____/ _____/ _____

Prognosis Stable: ______ Progressive: ______

Under our program, a person is considered visually impaired and eligible for services if he/she has "a visual acuity with best correction of 20/70 in the better eye, or a significant loss of visual fields, or has a corresponding impeding functional limitation." Does this person meet the above definition as someone who is visually impaired? No: ________ Yes: ________

## DOCTOR INFORMATION

Doctor's Signature/Name: ________________________________ Practice Name: _____________________

This referral is for evaluation and treatment.

Phone: _________________ Fax: __________________________

**Please Fax To: (717) 291-9183**

**Rehabilitation Services Department**
**244 North Queen Street**
**Lancaster, PA 17603**
**Phone: (717) 291-5951**