ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ 85210
480-924-8755

Please fax this form with patient insurance, demographics, last medical exam note, and any pertinent visual fields, OCT, retinal photography, or other diagnostic testing to 480-854-1864

Referral for Low Vision Consultation

Patient Name: _____ **Patient's Phone Number:** (__ __ __) __ __ __ - __ __ __ __

D.O.B. __ __ / __ __ / __ __ __ __ **Insurance carrier(s):** _____

Primary Diagnosis (please circle one):

	Right Eye →	**0 Normal**	**1 Mod. VI**	**2 Severe VI**	**3 Blindness**	**4 Blindness**	**5 Blindness**
Left Eye ↓		20/60 or better	20/61 - 20/200	20/201- 20/400	20/401- 20/1200	20/1201- LPO	NLP
0 Normal	20/60 or better		H54.511A	H54.512A	H54.413A	H54.414A	H54.415A
1 Mod. VI	20/61 - 20/200	H54.52A1	H54.2X11	H54.2X21	H54.1131	H54.1141	H54.1151
2 Severe VI	20/201- 20/400	H54.52A2	H54.2X12	H54.2X22	H54.1132	H54.1142	H54.1152
3 Blindness	20/401- 20/1200	H54.42A3	H54.1213	H54.1223	H54.0X33	H54.0X43	H54.0X53
4 Blindness	20/1201- LPO	H54.42A4	H54.1214	H54.1224	H54.0X34	H54.0X44	H54.0X54
5 Blindness	NLP	H54.42A5	H54.1215	H54.1225	H54.0X35	H54.0X45	H54.0X55

Additional diagnoses and codes (Ocular Disease causing Low Vision, Field Defects, etc.):_____

_____

Best Corrected Distance Acuity **Best Corrected Near Acuity**

OD: _____ OS: _____ OD: _____ OS: _____

Describe Visual Field Defects:_____

A low vision evaluation is being requested because patient is having difficulty with the following: (Check all that apply)

__ Near Tasks (reading print, mail, managing finances, etc.)
__ Distance Tasks (driving, seeing faces, watching television, etc.)
__ Photophobia (difficulty with glare or visual discomfort)
__ Mobility (constricted visual field, dependent on sighted guide)
__ Vocational (maintaining or finding work, college studies)
__Other:_____

Additional Comments:_____

_____

Date of last dilated eye examination: __ __ / __ __ / __ __ __ __

Fax number for reporting back to referring doctor: (__ __ __) __ __ __ - __ __ __ __

Physician Signature: _____ **Date:** __ __ / __ __ / __ __ __ __