Lighthouse Guild

REFERRAL TO LIGHTHOUSE GUILD FOR LOW VISION REHABILITATION SERVICES

Please evaluate my patient (name) _____ ☐ for low vision services ☐ OT evaluation for technology

Patient Information

Date of Birth: _____ Telephone: _____

Address: _____ City/State/Zip: _____

If language other than English, please specify: _____

Visual Acuity: OD _____ OS _____

Visual Field: _____ 20 degrees or less? OD ◯ yes ◯ no OS ◯ yes ◯ no

If visual field 20 degrees or less, please provide a copy of the latest results

Eye diagnosis:_____

Secondary eye diagnosis, current eye medications, and surgical history: _____

_____

Is the patient legally blind? ◯ yes ◯ no If legally blind, please add social security number_____

Insurance provider: ☐ Medicare ID number: _____ Other (specify): _____

☐ Medicaid ID number: _____ ID number: _____

Functional difficulties due to vision loss

☐ reading, writing ☐ identifying medications ☐ moving around safely (falls)

☐ household activities ☐ getting/keeping a job ☐ feeling nervous, anxious or on edge

☐ using cell phones or other technology ☐ feeling down, depressed or hopeless

Physician Information

Physician's name: _____ NPI# _____ Specialty:_____

Physician's signature: _____

Business Address: _____ City/State/Zip: _____

Telephone: _____ Fax: _____ Email: _____

Please return to Lighthouse Guild

250 West 64th Street, New York, NY 10023

ATTN: Jocelyn A. Tapia • Fax: 212-769-7848 • Email: lowvisionreferrals@lighthouseguild.org

To ensure compliance with HIPAA security standards, **emails must be encrypted.**

Patient Signature

I understand that a copy of this form will be faxed to Lighthouse Guild and that a representative may contact me or my practitioner to facilitate this referral. All information will be kept confidential.

Signature: _____ Date: _____