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: Angelica Rosario • 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: ____________________________