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THE LOW VISION CENTERS OF NORTH CAROLINA

www.lowvisionnc.com

Fax this form to 910-256-6617

LOW VISION CONSULTATION REQUEST

Date: _____

Patient Full Name: _____

Patient Phone Number: _____ **Patient Date of Birth:** _____

Patient Address: _____

Last Eye Exam Date: _____

- ☐ **Macular Degeneration**
- ☐ **Stargardt Disease**
- ☐ **Diabetic Retinopathy**
- ☐ **Glaucoma**
- ☐ **Optic Atrophy**
- ☐ **Albinism**
- ☐ **Stroke**
- ☐ **Other** _____

Best Corrected Distance Visual Acuity:

OD	OS	OU

Patient Rx:

OD	**add**
OS	**add**

Other information, if any:

Referring Provider: _____ **Phone:** _____

Clinic Name: _____ **Fax:** _____

Thank you for your kind referral, we look forward to working with you and your patient.