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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.