New England Low Vision and Blindness

Providing visual independence through technology, training, and care.

Patient Referral Form

Patient Referral Guidelines:

(1) 20/100 to 20/800 in their better eye
(2) Needs a 5X (or stronger) magnifier to function
(3) Unable to drive due to visual limitations

Referring Doctor: _____ Date: _____

Patient Name: _____

Patient Phone:_____

Patient Address:_____

Alternate Contact Details: _____

Patient's Signature:_____

Helpful information

Eye Condition: _____

Visual Acuity: OD 20/_____ OS 20/_____

Is your patient a U.S. Veteran? Yes_____ No_____

Comments:_____

_____

Please Send to Secure Fax: 844.364.2649

A representative from New England Low Vision and Blindness will contact your patient and keep you informed. Thank you for your continued trust in us for all your low vision and blindness technology and training needs.

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