VISION REHABILITATION SERVICES
PATIENT REFERRAL FORM

Referral Date: ______________________________

Patient Name: ______________________________
Patient Phone: ______________________________
Date of Birth: ______________________________
Referring Doctor: ____________________________

REASON FOR REFERRAL:

☐ Activities of Daily Living
☐ Orientation and Mobility
☐ Access Technology
☐ Adjustment to Blindness

DIAGNOSIS: __________________________________________________________________________

Visual Acuity: OD _________________________ OS _________________________

Visual Field Impairment: __________________________________________________________________

Doctor’s Signature: _________________________ Date: ____________________________

Please fax the completed form to (727) 544-5511 or email to referrals@lhpfl.org.