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.

6925 112th Circle North, Suite 103 | Largo, Florida 33773 | (727) 544-4433 | (727) 544-5511 fax | www.lhpfl.org

ACCREDITED BY: National Accreditation Council (NAC) for Agencies Serving People With Blindness or Visual Impairment. Funded in part under agreement with the Division of Blind Services, State of Florida, Department of Education