THE FRANK STEIN AND PAUL S. MAY CENTER FOR LOW VISION REHABILITATION

LOW VISION REHABILITATION REFERRAL

Thank you for choosing to refer your patient to us. To start the referral process, **fax the following to 415-430-9748**:

1) This *completed* referral form
2) Recent patient notes, including test results/ imaging
3) HMO authorization (if applicable)

Once we receive the information, we'll call your patient to set up an appointment.

Provider Name: _____

Address/Zip: _____

(P): _____ **(F):** _____ **(E):** _____

Preferred Communication (highlight or circle): P | F | E

☐ **Referral for evaluation and treatment to address deficits in performance:**
- ☐ **Activities and daily living such as reading medication labels/ bills**
- ☐ **Safe mobility and navigation**
- ☐ **Community/ peer support**

Referring Diagnosis: **ICD-10:** _____

- ☐ **Macular Degeneration:** ☐ Dry ☐ Wet
- ☐ **Glaucoma**
- ☐ **Diabetic Retinopathy**
- ☐ **Retinitis Pigmentosa**
- ☐ **Other:** _____

Patient Name (Last, First): _____ **DOB:** _____

GENDER: M | F | OTHER: _____ **PHONE:** _____

HOME ADDRESS: _____

PRIMARY INSURED NAME (if other than patient): _____

MEDICARE: YES | NO **INSURANCE COMPANY (if other):** _____

INSURANCE #/ID: _____ **HMO:** YES | NO