REFERRAL FOR LOW VISION SERVICES

Instructions: Complete and sign form. Completion of this form is voluntary.
Return to the address listed below.
Questions? Call: 608-237-8107

FROM: (Eye Care or Health Care Professional)	**TO: Wisconsin Council of the Blind & Visually Impaired** **Attn: Amy Wurf, Low Vision Therapist** **754 Williamson Street** **Madison, WI 53703** **FAX: 608-255-3301**
Client Name (Last, First):	**Client Birthdate (mm/dd/yyyy):**

Client Mailing Address:	**City:**	**County:**

Zip Code:	**Telephone (with Area Code):**	**Date of Last Eye Exam (mm/ddyyyy):**

Acuity (best corrected)(Snellen)	**OD:**	**OS:**
Field in degrees (if available)	**OD:**	**OS:**

Primary Diagnosis:

Is this person legally blind? Yes ☐ **No** ☐

Other Medical Issues – Please Specify:

Remarks (use additional sheet if needed):

Signature (Certifying Authority):	**Date Signed:**

Wisconsin Council of the Blind and Visually Impaired
754 Williams Street, Madison WI 53704