REFERRAL FOR LOW VISION SERVICES

Instructions: Complete and sign form. Completion of this form is voluntary. Return to the address listed below.

FROM: (Eye Care or Health Care Professional)	**TO:** **WI Council of the Blind & Visually Impaired** **Attn: Amy Wurf, Low Vision Therapist** **754 Williamson Street** **Madison, WI 53703** **Phone: 608-237-8107** **FAX: 608-255-3301**
Client Name: (last, first)	**Birthdate: (mm/dd/yyyy)**
Mailing Address:	**City:** / **County:**
Zip Code: / **Telephone #: (with area code)**	**Date of Last Eye Exam: (mm/dd/yyyy)**
ACUITY (best corrected)(Snellen)	**OD:** / **OS:**
FIELD in degrees (if available)	**OD:** / **OS:**
Primary Diagnosis:	**Age at Onset:**

Prognosis/Future Treatments Planned:

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

Other Medical Issues – Please Specify:

Remarks (use additional sheet if needed)

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