



LOW VISION REHABILITATION PATIENT REFERRAL FORM

Dr Grace Tran Chi, OD, FAAO

Referring Doctor _____

Office Phone _____ Fax _____

Patient Name _____

Birthdate _____

Phone Number _____

Date of Last Exam _____

Visual Condition(s) *Please check all that apply*

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Corneal | <input type="checkbox"/> Optic Atrophy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinitis Pigmentosa |

Other _____

Best Corrected Visual Acuity OD _____ OS _____