DIAMOND VISION
EYE CENTER

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*

- ☐ Cataract
- ☐ Corneal
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Optic Atrophy
- ☐ Retinitis Pigmentosa

Other _____

Best Corrected Visual Acuity OD _____ OS _____

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