REFERRAL TO INSIGHT

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CONFIDENTIAL REPORT OF EYE EXAMINATION

Patient Name:____ Gender: M / F

Address: ____

City: ____________________________ State: ___________ Zip Code: _________________

Phone: _______________________________ Date of Birth: ___________________________

Date of most recent eye exam: ________________________ Legally Blind: Yes / No

A. Visual Acuity (with best correction):

	Distant	Near
O.D.	________	________
O.S.	________	________
O.U.	________	________

B. Current Prescription: O.D. ________________________ O.S. _________________________

C. Visual Fields: Normal: ____________ Restricted:_____________

Ocular condition(s) responsible for visual impairment:

____

____

Etiology:

OD/OS/OU ___________________________

OD/OS/OU ___________________________

Probable age at onset of visual impairment: ____

Previous Surgery and/or Treatments: ___ Cataracts ___ Laser ___ Cornea ___ Other

Visual impairment is: ___ Stable ___ Deteriorating ___ Capable of Improving

Recomended Services: ___ Low Vision Evaluation ___ Independent Living Skills ___ Diabetes Education

Referring Physician: __________________________________ Date: ________________

Signature: ____