Casper Vision Center

LOW VISION REFERRAL FORM

Patient name:_____ DOB:_____

Other contact (if needed):_____

Address:_____

Phone number:_____

Diagnosis:_____

Reason for referral/please describe patient needs as you know them:

To assist in caring for your patients please include current clinical notes or patient records. This allows us to avoid repeating services.

Did you perform a comprehensive eye examination?

- Yes
  - Date:_____
  - Dilation performed
  - Records attached
  - Most recent visual field attached
  - BCVA: OD_____ OS_____ OU_____
- No

May we contact the patient for an appointment?

- Yes
- No

Referring physician/provider:_____

Phone number:_____ Fax:_____

Please send this completed form with any pertinent records to:
Fax: 307-237-1370 Email: visiontherapycvc@gmail.com
Thank you for your referral, we look forward to working with you!