ASSOCIATION FOR THE BLIND & VISUALLY IMPAIRED

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FAX for Client Referral and Clinical Records (616) 741-1342

VISION REHABILITATION/LOW VISION CLINIC REFERRAL

Please fax this completed form along with your most recent chart notes or eye report to (616) 741-1342.

☐ The patient plans to call ABVI to schedule the appointment.

☐ Please call the patient to schedule the appointment.

Patient's name:________________________________

D.O.B:________________

Address:____

Home phone: ____________________ Cell phone:_______________

Diagnosis: ____

Visual Acuity OD: ____________________ OS:_______________

Visual Field: ____

Goals/Reason for Referral: ________________________________

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Additional Comments:____________________________________

____

Referring Doctor: ________________________

Phone:____________________

Address:

____ Date:__________

Please give the patient a copy of our brochure or direct them to look up our website at www.abvimichigan.org. We will mail a packet of information to be completed and brought to the appointment once we have contacted the patient and made a clinic appointment. Thank you for your continued support.