ASSOCIATION FOR THE BLIND & VISUALLY IMPAIRED

456 Cherry St. SE • Grand Rapids, MI 49503 • ph. 616.458.1187
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FAX for Client Referral and Clinical Records (616) 840-9528 or (616) 458-7113

VISION REHABILITATION/LOW VISION CLINIC REFERRAL

Please fax this completed form along with your most recent chart notes or eye report.

☐ 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:_____

Medical insurance(s) and policy numbers: _____

Diagnosis: _____

Visual Acuity OD: _____ OS:_____

Visual Field: _____

Goals/Reason for Referral: _____

☐ Low vision clinic ☐ Braille teaching ☐ Orientation & Mobility Instruction

☐ Low vision rehabilitation

Referring Doctor: _____Medical Ins Name/#:_____

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 contact the patient to make a clinic appointment. Thank you for your continued support.