REFERRAL FORM

Date of this report: ______________________ Patient Telephone #: ______________________

Applicant's Name: ______________________ Other Contact Telephone #: ______________________

Birthdate: ______________________ Address: ______________________
(Street)

____
(City) (State) (Zip) (County)

Please attach relevant exam records and visual fields. If records are unavailable or incomplete, please fill out the following information:

VISUAL ACUITY (Best Corrected)

	Distance	Near
OD:	____________	____________
OS:	____________	____________

REFRACTION: Please indicate when last refraction was conducted: ______________________

OD: ______________________

OS: ______________________

VISUAL FIELDS: OD:______________________ OS:______________________

ICD-10 CODES*

OD: ______________________

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OS: ______________________

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DIAGNOSIS DESCRIPTION*

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***Please provide code and description, and include the code(s) that is the cause of vision impairment or blindness.**

PROGNOSIS ______________________

Other doctors providing eye care to this patient (including referrals): ______________________

Signature of examining eye doctor: ______________________

Name: ______________________ Date of examination: ______________________

Address: ______________________

Notes:______________________

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2045 Gilbert Avenue, Cincinnati, Ohio 45202
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