



# Request for Low Vision Assessment

Date \_\_\_\_\_

## Physician Information

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

## Patient Information

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

## Patient's Condition

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Treatment History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current prescription and expected visual acuity:

OD \_\_\_\_\_ 20/ \_\_\_\_\_

OS \_\_\_\_\_ 20/ \_\_\_\_\_

You can fill in this PDF electronically and submit it to Visual Rehab by clicking the **Submit** button  
OR

print this sheet out and **fax** the completed sheet to 613-228-8635.