eye clinic of wisconsin™
One vision. Yours.®

Practice_____
Doctor_____
Address_____
City, State, Zip_____
Phone: _____Fax: _____

Low Vision Referral Form

Low Vision Program

Name: _____ DOB: _____/_____/_____

Address: _____ State _____ Zip _____

Telephone: _____ Alternate Number: _____

Insurance Plan: _____ ID #: _____Self-Pay ☐

The most recent examination was on _____/_____/_____.

Visual Complaints: _____

Most Recent Refraction:

Sphere	Cylinder	Axis	Prism	Base	Add
		x			
		x			

Best Corrected Visual Acuity

OD 20/_____

OS 20/_____

Other Pertinent Information/Ocular History: _____

_____

Please send any previous fundus photos and visual fields along with this form.

Please fax this completed form to: (715) 870-2401. 9/2/22