Low Vision Referral
Patient's Eye Report

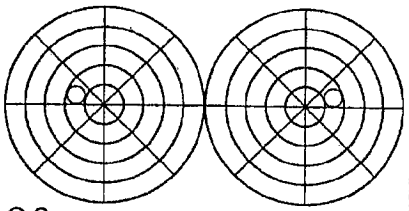
Please send to:
Division of Services for the Blind and Visually Impaired
250 North 1950 West, Suite B
Salt Lake City, UT 84116-7902
Phone: (801) 323-4343 or 1-800-284-1823
Fax: (801) 323-4396

Name of Patient:	**Phone:** ( )
Address:	**City:** **Zip:**
Date of Birth: **Sex:** ☐ M ☐ F	**Today's Date:**

Date of Examination:

A. Visual Acuity:	**Distance Vision** W/O Correct.	W/Correct.	**Near Vision** W/O Correct.	W/Correct.
O.D.				
O.S.				
O.U.				

B. Field of Vision
Please indicate field if restricted.



Most recent Rx:

O.D.	Add
O.S.	Add

Cause of vision impairment or blindness:

Other ocular history or involvements:

PROGNOSIS
Is patient's vision considered: ☐ Stable ☐ Deteriorating ☐ Uncertain

EYE DOCTOR CERTIFICATION: (Please note that the following certification should be based on the patient's vision in the best eye with best correction.)

I hereby certify that the above-named patient is:

☐	Legally Blind (20/200 or less vision or ≤ 20° visual field)
☐	Visually Impaired (20/70 to 20/200 vision or 20° to 30° visual field)
☐	DSBVI Services Eligible (20/50 to 20/70 deteriorating vision)
☐	DSBVI Services Eligible due to functional vision impairment of physiological origin – please describe (Psychological problems or learning disabilities are <u>not</u> qualifying conditions.)

Comments or Recommendations:

Doctor's Signature	
Printed or Typed Name	
Address	
City, State, Zip	
Telephone #	