REFERRAL FORM FOR CLINICAL LOW VISION EVALUATION

Northwest Hills Eye Care
dba Low Vision Services of Austin
3921 Steck Ave. #A-121
Austin, TX 78759
512-328-0555
FAX 512-340-0009

Appointment date:
Paperwork due: **One week prior**
Include with this form: (check when completed)
☐ Previous records
☐ Permission for exam and use of eye drops
☐ Is State Eye Exam form needed? Check if YES

Student/patient name:
Address:
City, State Zip
Phone 1: – –
Phone 2: – –
Date of Birth: – –
Medications:
Allergies:
Eye doctor(s):
Date of last eye exam:
Eye Diagnosis
DBS Caseworker:

Referring source:
Address:
City, State Zip
Phone: – –
FAX: – –
Email:

Parent/guardian/primary caretaker: Name:
Relationship to patient:
Email address:
☐ N.A. (Patient/student is his/her own legal guardian)

Special Needs:
☐ Sign Language Interpreter needed? Yes / No (circle)
☐ Wheelchair
☐ Spanish or other languages, please specify:
☐ Other:

Reading Level:
☐ Non-reader
☐ Pictures
☐ Single letters or numbers
☐ *Primary (grades 1-3)
☐ *Intermediate (grades 4-6)
☐ *Secondary (grades 6+)
☐ *Adult/Higher Education level

*Reading rate: Reads ___ size print at _____ wpm. Note with/without glasses, devices, lighting

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Reason(s) for Referral: (check all that apply)
☐ Initial Low Vision examination
☐ Low Vision Re-evaluation, DATE of last LVE: ____-____-____
☐ Measure visual acuities and visual fields
Evaluate for glasses
☐ Evaluate for specific low vision devices
☐ Evaluate for non-optical devices
☐ Address specific questions or issues (please list)

Specific issues:

- ☐ Eligibility for VI services
- ☐ Disability determination
- ☐ Eligibility for DARS DBS
- ☐ Print vs. Braille
- ☐ Eligibility for driving
- ☐ Other issues (please describe)

Please check any/all corrective lenses, devices, non-optical adaptations currently being used:

- ☐ Glasses
- ☐ Contact lenses
- ☐ Sunglasses
- ☐ Cap, Visor

Low Vision Devices

- ☐ Magnifier (power/ type)
- ☐ Monocular telescope (power)
- ☐ Binoculars
- ☐ Spectacle mounted microscope (special reading glasses)
- ☐ Spectacle mounted telescope or bioptic
- ☐ CCTV or Video Magnifier:
  Circle one: desk top or portable size
- ☐ Other _____

Computer Software

- ☐ Print enlarging
- ☐ Screen reader (speech output)
- ☐ Combination

Non-optical devices

- ☐ Special Lighting or environmental adaptations
- ☐ Cane (specify type)
- ☐ Other: (i.e., line guide; tinted overlay) Please specify

Please provide any additional questions, considerations or concerns you would like to have addressed during this evaluation. Use additional page if needed.

The following records MUST be submitted with this referral form:
Copies of eye examinations, any previous low vision evaluation reports, other pertinent data such as functional vision and learning media assessments, print reading assessment, orientation and mobility reports, and other pertinent medical data for this referral. **For minor children who will not be accompanied by a parent or legal guardian, two permission forms must be signed and submitted: Permission for Low Vision Exam and Permission for Use of Eye Drops.**

Return this form plus additional records to NW Hills Eye Care, Attn: Dr. Laura Miller, via hard copy or electronic mail (drlaura@nwhillseyecare.com) or FAX to 512-340-0009 **ONE WEEK prior to appointment.** Late paperwork will require rescheduling appointment.
A $75.00 processing fee will be incurred if the patient “no-shows” without 24-hour prior notice.
If patient is more than 15 minutes late for an appointment, a $25.00 late fee will be charged.