Referral for Low Vision Occupational Therapy
Regina Budet, OTR
"Independent Living with Low Vision"

Patient Information

Name_____

Address_____

Phone_____ **Birthdate**_____

Medical Information

ICD10: _____

Corrected Visual Acuity:

Right Eye_____

Left Eye _____

Cause(s) of Vision Loss:

Right Eye_____

Left Eye _____

Visual Field Defect?

Please Describe: _____

Please attach most recent Examination findings and relevant patient history information.

Please send/ Fax to:
Northwest Hills Eye Care
3921 Steck Ave. #A-121
Austin, TX 78759
T: 512-328-0555 F: 512-340-0009
regina@nwhillseyecare.com