Low Vision
Consultation Request

Name: _____ Phone: _____

Address: _____ D.O.B.: _____

_____ S.S.N: _____

Contact Person/Relationship: _____ Phone_____

Primary Insurance: _____ ID#_____ Group_____

Secondary Insurance: _____ID# _____Group_____

*****PLEASE FAX COPIES OF INSURANCE CARDS ALONG WITH THIS FORM!!!*****

Office Use Only : Compulink___ Google___ Contact Dates/Times: 1.___/___/___@_____LM/NA
2. ___/___/___@_____LM/NA 3.___/___/___@_____LM/NA

Current Acuity (BVA): OD 20/_____ OS 20/_____

Diagnosis: OD _____ Stable/Uncertain

OS _____ Stable/Uncertain

Date of Last Exam: _____

I am referring this patient for Low Vision Consultation.

Print Referring Doctor Name: _____NPI: _____

Signature of Referring Doctor: _____ Date: _____

Referring Doctor's Address: _____

Phone _____ Fax_____

Please fax completed consultation form, copies of insurance cards, any pertinent records including diagnosis & any testing, to (316) 440-1695.

Donald Fletcher, MD

610 N. Main, Suite 211 Wichita, KS 67203

Phone (316) 440-1681 / Fax (316) 440-1695