Doctor Referral Form for Vision Rehabilitation Services

To the doctor: Please complete, and fax with recent chart notes to the appropriate center (see list on right side).

Braille Institute®

1-800-272-4553
BrailleInstitute.org

LOCATIONS

Los Angeles
741 N. Vermont Ave.
Los Angeles, CA 90029
(323) 663-1111
fax (323) 663-0241

Anaheim
527 N. Dale Ave.
Anaheim, CA 92801
(714) 821-5000
fax (714) 527-7621

San Diego
9635 Granite Ridge Dr., #130
San Diego, CA 92123
(858) 452-1111
fax (858) 452-1688

Santa Barbara
2031 De La Vina St.
Santa Barbara, CA 93105
(805) 682-6222
fax (805) 687-6141

Coachella Valley
74-245 Highway 111, #E101
Palm Desert, CA 92260
(760) 321-1111
fax (760) 321-9715

Laguna Hills
24411 Ridge Route Dr., #110
Laguna Hills, CA 92653
(949) 330-5062
fax (949) 330-5067

Riverside
6974 Brockton Ave., #100
Riverside, CA 92506
(951) 787-8800
fax (951) 344-8386

Patient's First Name _____ **Patient's Last Name** _____

Address _____ **City** _____ **Zip** _____

Date of Birth _____ / _____ / _____ **Gender** ☐ Male ☐ Female

Email Address _____

Home Phone _____ **Cell Phone** _____

	OD	OS
Corrected Distance Acuity		
Corrected Near Acuity		
Current Prescription		
Near Add		
IOL	☐ Yes ☐ No	☐ Yes ☐ No
Is visual field reduced to 20" or less?	☐ Yes ☐ No	☐ Yes ☐ No

Diagnosis _____ **Date of Last Exam** _____

Occupational Therapy evaluation and treatment

1. ☐ **I recommend client usage and training as needed for optical devices by the OTR/L and/or O&M.**
2. ☐ **I certify that the name above is legally blind.**

Note: Both visually impaired and blind individuals can receive services from Braille Institute.

Additional Information: _____

Doctor's Name _____ CHECK ONE: ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST ☐ PHYSICIAN

Address _____ **Suite #** _____ **City** _____ **Zip** _____

Office Phone _____ **Fax Number** _____

Group Affiliation _____ **Email Address** _____

Doctor's Signature * _____ **Date** _____

* Your typed name represents your signature on this form.