Low Vision Center of Northeast Florida

Date:_____

Referring Provider: _____

Telephone Number: _____

Fax Number: _____

Provider NPI : _____

The following patient is in need of a low vision evaluation and visual rehabilitative services due to his/her ocular condition.

Patient Name:_____

Date of Birth:_____

Patient's Phone Number: _____

Patient's Insurance: _____

Diagnosis/Acuities OD:_____

OS:_____

Please fax this referral form along with a copy of most recent examination and any other pertinent information to:

Low Vision Center of Northeast Florida
Diane M. Cates, OD
Fax Number: (904) 389-1060
Phone Number (904) 389-9989
www.jacksonvillelowvision.com