Referral for Low Vision Consultation and Out Patient Occupational Therapy Rehabilitation

Low Vision Consultations require a referral from the patient's current primary care or eye care provider. Please complete section 1 and sign. Complete as much of section 2 as possible.

Section 1	
Referring Doctor/Agency	
Address	
City, ST, Zip	
Phone Number	
NPI #	
Signature:	

Section 2	
Patient Name	
Address	
City, ST, Zip	
Phone Number	
Insurance Provider(s)	
Date of Birth	
Ocular Diagnosis	
Onset Date	
Latest Refraction & Acuity	OD: OS:
Other Information	

In addition to this form, please send the most recent eye exam.

Please FAX or Mail this information. A report will be sent to you following the evaluation. If you have any questions, please contact our office.

Mail To: Kendall Krug, OD
2203 Canterbury Dr.
Hays, KS 67601
Phone Number: 785-625-3937
FAX Number: 785-625-7490