LOW VISION CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____

DATE OF BIRTH _____

DATE OF EXAM _____

REFERRING DOCTOR _____

□ I have scheduled an appointment for this patient.

□ I would like Sightline to call this patient to schedule:

PATIENT PHONE _____

CURRENT REFRACTION: DATE: _____

R _____ 20/_____

L _____ 20/_____

EYE HEALTH HISTORY AND CAUSE OF LOW VISION DEFICIT:

_____ Report Faxed to SightLine

Signature _____