New York Eye and Ear Infirmary of Mount Sinai

PATIENT REFERRAL FORM FOR LOW VISION REHABILITATION SERVICES

Please evaluate my patient (Name)

Patient Information

Date of birth (xx/xx/xxxx) Phone Email

Address/City/State/Zip

If language other than English, please specify

OD OS

Visual acuity

OD ◯ Yes ◯ No OS ◯ Yes ◯ No

Is the visual field 20 degrees or less?

If visual field 20 degrees or less, please provide a copy of latest results.

Eye diagnosis

Secondary eye diagnosis, current eye medications, and surgical history

Insurance provider

◯ Medicare ID number

◯ Medicaid ID number

◯ Other (specify) ID number

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Functional difficulties due to vision loss (check all the apply):

- ◯ Reading
- ◯ Writing
- ◯ Getting/keeping a job
- ◯ Moving around safely/falls
- ◯ Using cell phones or other technology
- ◯ Household activities
- ◯ Seeing street signs or bus signs/numbers
- ◯ Other _____

Referring Physician

Physician's Name _____ Physician's Signature _____

Business address/City/State/Zip _____

Phone _____ Fax _____ Email _____

Please return the completed form along with a copy of the patient's last chart to:

EyeReferral@mountsinai.org or fax to 212-979-4512. Your patient will be contacted for an appointment at one of the following locations:

NYEE-Eye Clinic: 310 East 14th Street, 1st Floor-South Bldg., NY, NY 10003

NYEE-Upper East Side: 17 East 102nd Street, 8 Floor-West, NY, NY 10029

NYEE Faculty Practice: 310 East 14th Street, Suite 319, NY, NY 10003

Patient's Signature: I understand that a copy of this form will be sent to New York Eye and Ear Infirmary of Mount Sinai Low Vision Services and that I or my practitioner will be contacted to facilitate this referral. All information will be kept confidential.

Patient's Signature _____ Date _____