



Request for Low Vision Assessment

Date _____

Physician Information

Doctor's Name _____

Address _____

City _____

Phone _____

Patient Information

Patient's Name _____

Address _____

City _____

Phone _____

Patient's Condition

Treatment History

The best-corrected vision following a careful refraction was:

OD 20/____

OS 20/____

My refraction did did not indicate a significant change for his/her habitual Rx.

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