VISUAL REHAB
LOW-VISION DEVICES

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.

Please print this form and submit via Fax to 613-228-8635