Low Vision Exam Referral

VISTA CENTER
for the blind and visually impaired

Thank you for referring your patient to our Vista Low Vision Clinic.

Date of referral: _____

Patient Information:

Name:_____Date of Birth:_____

Address:_____City/State/Zip:_____

Phone number:_____Email:_____

Diagnosis:_____ Diagnosis code(s):_____

Visual Acuity: OD_____OS_____Preferred Language:_____

Is eye condition currently stable?_____Date of last exam:_____

Please attach Chart Notes: This referral requires the last exam notes within a 12 month period.

Vista Services Requested:

- ○ Low Vision Evaluation
- ○ Social Services/Support in Adjusting to Vision Loss
- ○ Orientation and Mobility Training
- ○ Daily Living Skills
- ○ Assistive Technology

Medical Insurance: (Copies of insurance cards required)

☐ Medicare ID Number:_____

☐ Medicare + Supplemental ID Number_____

☐ Self-Pay ($450 LVE)

☐ Medi-Cal

☐ No Insurance

*We do not accept PPO or HMO insurance.

REFERRED BY: _____**NPI:**_____ **Date:**_____

Office or Agency: _____

Address: _____City/State/Zip_____

Phone Number: _____**FAX**: _____

☐ 101 N. Bascom Avenue
SAN JOSE, CA 95128
408-483-4325
408-295-1398 FAX

☐ 2500 El Camino Real Suite 100
PALO ALTO, CA 94306
650-858-0202
650-858-0214 FAX

☐ 3315 Mission Drive, Suite B
SANTA CRUZ, CA 95065
831-458-9766
831-426-6233 FAX
Patients seen in San Jose for Low Vision Exams