

Patient Referral Form

Low Vision Services

Las Vegas Comprehensive Vision Center for
the Partially Sighted

*"The Greater The Vision Loss, The More We
Can Help"*



Refer When Visual Acuity > 20/50 or Constricted Visual Fields

Dr. David YESnick

Sandy YESnick

Low Vision Optometry

**Licensed, Board Certified Low
Vision Therapist**

**Fax Completed Form to: (702) 966-2022; or e-mail to
DrYESnick@cox.net P: 966-2020**

Date: _____

Refer for Low Vision Optometric & Vision Rehab Therapy Eval

Patient Name: _____ Phone(H) _____ (C) _____

Insurance(s): _____ DOB _____

Referring Doctor: _____ Phone _____

Dr. Signature: _____ Fax _____

Mark Applicable Diagnoses:

- | | |
|--|--|
| <input type="radio"/> Macular Degeneration | <input type="radio"/> Degenerative Myopia |
| <input type="radio"/> Diabetic Eye Disease | <input type="radio"/> Inoperable Cataracts |
| <input type="radio"/> Glaucoma | <input type="radio"/> Stroke Related Vision Loss |
| <input type="radio"/> Optic Atrophy | <input type="radio"/> TBI |
| <input type="radio"/> Nystagmus | <input type="radio"/> Ocular Albinism |
| <input type="radio"/> Keratoconus | <input type="radio"/> Retinal Detachment |

Notes _____

Exam Results: Fax: _____

Referring Dr.'s Email: _____