



Patient Referral Form

Phillips Eye Institute at Buffalo Hospital Low Vision Center

Phone: 763-684-3888
Fax: 763-684-3884

Patient Name:	Male	Female
Address:	County:	
City, State, Zip:	Phone #:	Other #:
Diagnosis:	DOB:	
Primary Insurance: ID # Group #	Secondary Insurance: ID # Group #	
Referring Physician:	Office Phone #:	
Address:	Office Fax #:	
City, State, Zip:	Primary Physician:	
Emergency Contact: Relationship:	Emergency Phone #:	

➔ REQUESTING INFORMATION:

Date of Last Exam:	Ophthalmic Diagnosis:
Uncorrected Visual Acuity OD:	Uncorrected Visual Acuity OS:
Best Corrected Visual Acuity OD:	Best Corrected Visual Acuity OS:
Comments:	

Please complete in full, sign, and enclose a copy of the patient's last exam and their latest visual field.

Physician Signature

Date

FOR OFFICE USE ONLY

Referring MD / OD

Initial Appointment Date: _____

Initial Appointment Time: _____