The Chicago Lighthouse
Alfred A. Rosenbloom
Low Vision Rehabilitation Service

1850 W. Roosevelt Rd., Chicago, IL 60608 Tel.312.997.3686 Fax.312. 997.3663

CONSULTATION REQUEST FORM

PATIENT INFORMATION

Patient's name _____

Address _____

Phone _____ Date of birth _____

DIAGNOSIS/CAUSE OF VISION LOSS _____

_____

VISUAL ACUITY: OD _____ OS _____

We are requesting LVR Consultation because the patient is having difficulty with the following tasks:

- ❑ **Near Tasks** (reading printed materials, seeing checkbook & bills)
- ❑ **Distance Tasks (**seeing street signs, faces, & television)
- ❑ **Photophobia** (indoor and outdoor glare)
- ❑ **Mobility** (hemianopsia, constricted fields)
- ❑ **Vocational** (maintaining or finding work)

DOCTOR INFORMATION

Doctor's name _____ NPI # _____
(Required for consult)

Address _____

Phone _____

Signature _____

Please return this completed form along with a copy of the patient's most recent eye exam to 312-997-3663 (fax), lowvisionconsults@chicagolighthouse.org (email), or by mail. We will call your patient to schedule an appointment. If you require additional Consultation Request Forms, please call (312) 997-3686.