

The Chicago Lighthouse Low Vision Clinic

1850 W. Roosevelt Rd. | Chicago, IL 60608 Tel: (312) 997-3686 | Fax: (312) 997-3663

Patient's name



The Chicago Lighthouse Vision Rehabilitation Center

222 Waukegan Rd. | Glenview, IL 60025 Tel: (847) 510-6200 | Fax: (847) 729-2207

CONSULTATION REQUEST FORM

Address		City/Zip				
Phone	Date of birth					
Diagnosis/Caus	e of Vision L	oss				
Visual Acuity: ()D	OS	_			
We are requesting	LVR Consulta	tion because t	he patient	is having diffic	ulty with the	e following tasks:
□ Near Tasks (r□ Distance Tas□ Photophobia□ Mobility (her□ Vocational (r□ Other	ks (seeing sto (indoor and mianopsia, co maintaining c	reet signs, fa outdoor gla onstricted fio or finding wo	aces, & te are) elds) ork)		bills)	
Doctor's name						
Address					(Requir	red for consult)
Phone						
Signature						
Please return f						
☐ Patient will Preferred locat ☐Chicago ☐Gle	tion:					

CLINIC LOCATIONS

Chicago

1850 W. Roosevelt Rd. Chicago, IL 60608

Glenview

222 Waukegan Rd. Glenview, IL 60025

Elk Grove Village

Eberle Medical Office Building at Alexian 800 Biesterfield Rd. Elk Grove Village, IL 60007

Northwestern Memorial

Dept. of Ophthalmology, Galter Pavilion 675 N. St. Clair, 15th Floor Chicago, IL 60611

Flossmoor

Ingalls Family Center, Room 1423 19550 Governors Hwy. Flossmoor, IL 60422

Tradewinds

3198 E. 83rd Pl. Merrillville, IN 46410



The Chicago Lighthouse Low Vision Clinic

1850 W. Roosevelt Rd. | Chicago, IL 60608 Tel: (312) 666-1331 | Fax: (312) 243-8539



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222 Waukegan Rd. | Glenview, IL 60025 Tel: (847) 510-6200 | Fax: (847) 279-2207

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CONSULTATION REQUEST FORM

Address	City/Zip				
Phone Date of birth					
Diagnosis/Cause of Visio	on Loss				
Visual Acuity: OD					
We are requesting LVR Cons	ultation because the patie	ent is having difficulty with the follow	ing tasks:		
 Near Tasks (reading p Distance Tasks (seeing Photophobia (indoorge) Mobility (hemianopsia Vocational (maintainia) Other 	g street signs, faces, & and outdoor glare) a, constricted fields) ng or finding work)				
		NPI#			
		(Required for c	consult)		
Signature					
Preferred location:		patient for appt. □ Appt. already r			
Place return this comp	loted form and convio	fthe nationt's most recent ave o	vam by		

Please return this completed form and copy of the patient's most recent eye exam by fax or mail. If you require additional Consultation Request Forms, please call.