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(907)248-7517 fax
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Equipping Alaskans who are blind and visually impaired with skills for success in life and work

Referral for Services

Date: ____

Name of individual being referred: _____________________________________

Contact number for individual being referred:_____________________________

Referral source:____

Eye Condition (list diagnoses/ICD-9 codes):

____

____

____

Best corrected acuity: DVA OS_________ OD_________ OU_________
(sc or cc)

NVA OS_________ OD_________ OU_________

Visual fields: ________________________

Pertinent history (surgeries/treatments): ______________________________

____

____

Treatment Plan: ____

____

Other Pertinent Medical Conditions: ____________________________________