Alaska Center
FOR THE BLIND AND
VISUALLY IMPAIRED

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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:_____

Contact Address:_____

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: _____

_____

_____

Please note if Clinic would like to receive the Low Vision Assessment once complete-

Yes ☐ **No** ☐

Please Note:
Due to the high demand for our services, referrals are placed on a waiting list. We will contact the individual being referred in order that referrals are received. Thank you for your understanding and patience.