BEACON VISION CENTER

Low Vision Consultation Request

Name: _____ Phone: _____

Address: _____ D.O.B.: _____

_____ S.S.N: _____

Contact Person/Relationship: _____ Phone_____

Primary Insurance: _____ ID#_____ Group_____

Secondary Insurance: _____ID# _____Group_____

********PLEASE FAX COPIES OF INSURANCE CARDS ALONG WITH THIS FORM********

Current Acuity (BVA): OD 20/_____ OS 20/_____

Diagnosis: OD _____ Stable/Uncertain

OS _____ Stable/Uncertain

Date of Last Exam: _____

I am referring this patient for Low Vision Consultation.

Print Referring Doctor Name: _____NPI: _____

Signature of Referring Doctor: _____ Date: _____

Referring Doctor's Address: _____

Phone _____ Fax_____

Please fax completed consultation form, copies of insurance cards, any pertinent records including diagnosis & any testing, to (214) 420-5091.

Thank you!!

Beacon Vision Center, PLLC – Dr. Amy Burcham, OD, FAAO

1801 Valley View Lane Farmers Branch, TX 75234

Phone (214) 420-5090 / Fax (214) 420-5091