N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

REFERRAL FOR LOW VISION EVALUATION

Name ______________________________ Date of Birth ______________________

Address ____________________________ Telephone # ______________________

__________________________________ Alt. Telephone # ____________________

County _________________ Zip ________ Contact Person _____________________

Eligibility Information ____________________ Living Situation _____________________

Reason for Referral: ____

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Directions to Home/ Work Site: ____

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Education __________________________ Occupation __________________________

Training ___________________________ Work Experience ______________________

Visual Acuity: OD ____________________ Visual Field: OD ____________________

OS ____________________ OS ____________________

Visual Diagnosis: ____

Please attach an eye report.

Pertinent Medical Problems/ Impairments/ Comments: __________________________________

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Referring Case Manager Date of Referral