Low Vision Rehabilitation Services
Patient Referral Form

Braille® Institute

To the doctor: *Please complete, and fax with recent chart notes to the appropriate center (see list on right side).*

Patient's First Name _____ **Patient's Last Name** _____

Address _____ **City** _____ **Zip** _____

Date of Birth _____ / _____ / _____ **Email Address** _____

Home Phone _____ **Cell Phone** _____

VISION HEALTH	O.D	O.S
Corrected Distance		
Acuity Corrected Near		
Acuity Current		
Prescription Near Add		
IOL *(please circle one)*	**Yes No**	**Yes No**
Is visual field reduced to 20" or less?	**Yes No**	**Yes No**

Diagnosis _____ **Date of Last Exam** _____

Occupational Therapy evaluation and treatment

☐ I certify that the name above is legally blind.

Note: *Both visually impaired and blind individuals can receive services from Braille Institute.*

Additional Information:

_____

_____

Doctor's Name CIRCLE ONE: OPHTHALMOLOGIST | OPTOMETRIST | PHYSICIAN

Address _____ **City** _____ **Zip** _____

Office Phone _____ **Fax Number** _____

Group/Affiliation Name _____ **Email Address** _____

Doctor's Signature _____ **Date** _____

1-800-272-4553
BrailleInstitute.org

LOCATIONS

Los Angeles Center
741 N. Vermont Avenue
Los Angeles, CA 90029
(323) 663-1111
fax (323) 663-0241

Anaheim Center
527 N. Dale Avenue
Anaheim, CA 92801
(714) 821-5000
fax (714) 527-7621

Rancho Mirage
70-251 Ramon Road
Rancho Mirage, CA 92270
(760) 321-1111
fax (760) 321-9715

San Diego
4555 Executive Drive
San Diego, CA 92121
(858) 452-1111
fax (858) 452-1688

Santa Barbara
2031 De La Vina Street
Santa Barbara, CA 93105
(805) 682-6222
fax (805) 687-6141

Laguna Hills Neighborhood Center
24411 Ridge Route Drive
Suite #110
Laguna Hills, CA 92653
(949) 330-5062
fax (949) 330-5067