L.A.B. COMMUNITY SERVICES
a division of Louisiana Association for the Blind

1714 CLAIBORNE AVE.
SHREVEPORT, LA 71103
318.698.2300
FAX: 1.888.990.0751

WWW.LABLIND.COM

PHYSICIAN REFERRAL

Patient Name: _____ Age: _____ D.O.B. _____

Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Date of last visit: _____

Primary Visual Diagnosis:_____

Best Corrected Visual Acuity	OD	OS	Visual Fields	OD	OS
Best Near			Peripheral		
Best Distance			Central		
IOP			*Include a copy of Visual Field with this referral form		

Current Eye Glass Prescription	OD	OS

Referring Physician: _____

☐ Ophthalmologist ☐ Optometrist ☐ Neurologist ☐ Internist ☐ Other: _____

Name of Clinic: _____

Phone: _____Fax: _____

I recommend the patient receive low vision services to assess and address their visual rehabilitation needs, promoting greater independence and enhancing daily living skills.

_____ _____

Physician Signature Date of Referral

Please email to: lvreferrals@lablind.com or fax: 1-888-990-0751

Phone Number : 318-698-2300

Thank you for your referral to Louisiana Association for the Blind.

For more information about our services, visit www.lablind.com