AURORA OF CENTRAL NEW YORK
REFERRAL FORM

1. **Is this person**
   ☐ Legally Blind (as declared by the doctor) OR
   ☐ Visually Impaired?

2. **If this patient is legally blind, have you registered them with the New York State Commission for the Blind (NYSCB)?**
   ☐ Yes ☐ No

3. **Please check the following services desired:**
   ☐ Vision Rehabilitation Services for Legally Blind
   ☐ Daily living skills assistance for Visually Impaired

Name: _____ **Phone**: _____

Address: _____ **DOB**: _____

City: _____ **State**: _____ **Zip**_____

Date of Last Exam: _____ **Insurance Policy/Member ID**_____

Diagnosis: (check one)

☐ Macular Degeneration
☐ Glaucoma
☐ Diabetic Retinopathy
☐ Other (specify) _____

Acuity (with best correction):

_____**O.D.** _____**O.S.**

Field in Degrees:

_____**O.D**. _____**O.S.**

Physician Name: _____ **Date:** _____

(Please PRINT)

I hereby authorize Dr. _____**to release eye related information to Aurora of Central New York, Inc.**

Patient Signature: _____

Witness Signature: _____

Please fax to Aurora at 315-422-4792 to the attention of the Intake Worker, Angela DeFrancis or email ADefrancis@auroraofcny.org

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