



The Center for

the Partially Sighted

CONSULTATION FOR LOW VISION SERVICES

FAX TO:

CULVER CITY

6101 W. Centinela Ave., Ste. 150
Culver City, CA 90230

EAGLE ROCK

7462 N. Figueroa Blvd., Ste. 103
Los Angeles, CA 90041

TORRANCE

**Adult services only*
22340 Hawthorne Blvd., Unit F
Torrance, CA 90503

Phone: (310) 988-1970

Fax: (310) 988-1980

TARZANA

18425 Burbank Blvd., Ste. 706
Tarzana, CA 91356

Phone: (818) 705-5954

Fax: (818) 705-6315

Patient's Name _____

Phone Number () _____

Date of Birth _____

Date of last exam _____ Date of last dilation _____

TO ASSIST IN CARING FOR YOUR PATIENTS, PLEASE PROVIDE CURRENT CLINICAL NOTES. THIS WILL ALLOW US TO AVOID REPEATING SERVICES.

Diagnosis _____

Prognosis of Visual Function: Good Stable Poor Guarded

Best Visual Acuity: Right Eye _____ Left Eye _____

Past ophthalmological treatment:

When would you like to see the patient again?

Which services would you like your patient to receive at CPS?

- | | |
|--|--|
| <input type="checkbox"/> Low Vision Optometry | <input type="checkbox"/> Pediatric Function Vision Assessment |
| <input type="checkbox"/> Diabetic Education | <input type="checkbox"/> Vision Therapy Consultation |
| <input type="checkbox"/> Counseling/Support Groups | <input type="checkbox"/> Family Resource Project |
| <input type="checkbox"/> Independent Living Skills | |
| <input type="checkbox"/> Orientation & Mobility Training | |
| <input type="checkbox"/> Technology Evaluation and Training (e.g., computers, CCTV) | |
| <input type="checkbox"/> Store | |

Doctor's Name: _____ NPI # _____

Address: _____

Phone _____ FAX _____

Doctor's Signature _____

Additional comments: _____

Please call my patient to schedule an appointment

Patient is Spanish-Speaking **Patient speaks** _____