Doctor's Address label/stamp here

Fax to:
(207) 774-0679
Or mail to:
The Iris Network Client Services
189 Park Ave
Portland, ME 04102

REQUEST FOR EVALUATION AND RELEASE OF INFORMATION

Patient Name: ___________________________________D.O.B. ______________ Phone #:_______________________

Address: ____ City/State/Zip: ____________________________________

My signature authorizes release of this information to The Iris Network and/or the Division for the Blind & Visually Impaired and is valid for one year. I have the right to withdraw my authorization to release information at any time.

X ________________________________ **Date:** _____/_____/________

Client Signature

Referring Physician Section

I am referring this patient to The Iris Network for comprehensive vision services, which may include one or more of the following services: **Vision Rehabilitation Services** (Vision Rehabilitation Therapist, Orientation and Mobility); **Low Vision Services** (Low Vision Evaluation, Occupational Therapy Evaluation and Treatment as appropriate).

DATE OF LAST EXAM: ____ /___ /_______

DIAGNOSIS: (If more than one, please circle the primary eye condition)

___________________________________ ___________________________________

OD OS

PROGNOSIS: ___________________________

VISION WITH BEST CORRECTION:

OD Distance _________ Near__________

OS Distance__________ Near__________

Ocular Medications:
____
____
____
____

Degree of Field Loss: _____________________________ **(if tested, please include copy)

Form completed by:______________________________________Fax #: _____________________________

Doctor's Signature: ____ **Date:** ________________________

****PLEASE SEND MOST RECENT EYE REPORT AND INSURANCE INFORMATION WITH THIS FORM****