DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-22469 (08/2017)

STATE OF WISCONSIN

REFERRAL FOR SERVICES FROM THE OFFICE OF THE BLIND AND VISUALLY IMPAIRED (OBVI)

INSTRUCTIONS: Complete and sign form. Completion of this form is voluntary. Return to the OBVI address listed below.

FROM: (Health Care Professional)	TO: (OBVI) OBVI Fax Number:

Name – Client (Last, First, Middle)	Date of Birth

Mailing Address - Street	City	Zip Code

County Name	Area Code and Phone Number	Date of Last Exam

ACUITY with best correction (Snellen Notation) Right Eye: Left Eye:	FIELD in degrees (if available) Right Eye: Left Eye:

Diagnosis

Age of Onset	Is Client Legally Blind ☐ Yes ☐ No

Prognosis

Other Disabilities (specify)

Remarks (use additional sheets if needed)

SIGNATURE – Certifying Authority	Date Signed