LIONS
LOW
VISION
SERVICES
PROGRAM

Lions Low Vision Services Program
Patient Referral Form
Loveprogram.org

Date_____

Patient Information
Ms.
Mrs.
Mr._____ **Birth date:** _____ **Age:**_____
Last Name **First Name**

Home Address_____
Street **City** **State** **Zip**
Home Phone (**)**_____**Cell number (** **)**_____
Ocupation:_____
Employer_____
Single_____ **Married**_____ **Other**_____ **Student**_____ **Grade / School**_____
Number of Dependents _____
Spouse, Parent or Guardian Information:
Name: _____ **Relationship:** _____ **Contact number (** **)**_____

Do you have insurance? YES____ **NO** ____
Name of Insurance _____
Last Eye Exam: Month/Year_____
Were Glasses/Contact Lenses Prescribed? YES_____**NO**_____
Type of Glasses/Contact lenses prescribed?_____
How old are the glasses/contacts?_____

Referred By:

Lions club: _____ Districts 4-_____ Members Name: _____

Agency /School_____ Contact Person_____ Tel# ( )_____

Reason for Referral:

Low Vision_____ Needs Glasses ONLY_____ Needs Eye Exam_____ Other_____

Describe Vision Problem (please circle any that apply)

Reduced Vision With or Without GL/CL	R__/__ L__/__	**Cataract**	R L	**Glaucoma** IOP	R___ L___	**Pterygium**	R L	**OTHERS**	R _____ L _____

Recommendation(s): _____

The Lions Low Vision Service (L.O.V.E) Program provides services based on patients ability to pay. For the truly indigent patient, the cost may be almost nothing. Regular fees will be charged for those who can afford to pay. All patients must either pay for services through personal funds as so state or request for financial assistance in part or in whole and agree to provide the necessary financial data to qualify for assistance.

EMAIL TO: lionsloveprogram@gmail.com
OR
FAX TO: (562) 924-5913
OR
Mail TO: LOVE PROGRAM
c/o Jennifer Tawagon-Cantillon
19230 Madeira Ct., Cerritos, CA 90703

_____
Print Name of Referring Individual

_____
Signature of Referring Individual