Rehabilitation Services Department
244 North Queen Street
Lancaster, PA 17603-5951
Phone: (717) 291-5951
Fax: (717) 291-9183

I HEREBY AUTHORIZE MY EYE CARE PROFESSIONAL DR. _____ AT PHONE NUMBER _____ TO RELEASE MY LATEST VISUAL ACUITY TO VISIONCORPS.

_____ X _____

DATE **SIGNATURE**

ADDRESS:

_____ **NAME:** _____

_____ **PHONE NUMBER :( )** _____

_____ **DATE OF BIRTH:** _____

Do you still drive: Yes____ No____?

(This section completed by eye care professional)

DATE OF LAST EXAM: _____/_____/_____ **Diagnosis:** _____

BEST CORRECTED VISUAL ACUITY:

DISTANCE: OD_____ **NEAR: OD**_____ **Field: OD**_____

OS_____ **OS**_____ **OS**_____

Prognosis: Stable _____ **Progressive** _____

Under our program, a person is considered visually impaired and eligible for services if he/she has "a visual acuity with best correction of 20/70 in the better eye, or a significant loss of visual fields, or has a corresponding impeding functional limitation." Does this person meet the above definition as someone who is visually impaired?

___ Yes **___No** _____

Signature

*** If possible please attach last copy of eye exam.