Patient Referral Form

- Complete and fax this form to CVI at 404-875-4568
- Please include a copy of the patient's latest eye report, if possible
- CVI will contact your patient to schedule an appointment

739 West Peachtree St. NW
• Atlanta, GA 30308
• Ph: 404.875.9011
• Fax: 404-875-4568
Accredited Member, National Accreditation Council United Way Agency

Patient Name: _____

Date of Birth: _____

Patient's Preferred Phone: _____

Address: _____

City/State/Zip: _____

Email: _____

Diagnosis: _____

Visual Acuities: Distance cc OD: _____ cc OS _____

Visual Fields (please fax field chart if available): _____

Referred by:

Physician's name (please print): _____
First Middle Last

Physician Practice/Location: _____

Physician's signature: _____

NPI: _____ Phone: _____

Address: _____

City, State, Zip: _____

Referral Date: _____ Date of Office Visit: _____

Recommended Location for Low Vision Evaluation

- ☐ CVI Main Clinic, Atlanta
- ☐ Georgia Retina, Braselton
- ☐ North Georgia Eye, Gainesville
- ☐ New Rock Day Treatment Center, Covington
- ☐ ViewPoint Health (Crews Center), Lawrenceville
- ☐ Eye Consultants of Atlanta, Cumberland
- ☐ Southwest Christian Care, Union City
- ☐ Eye Physicians & Surgeons, Decatur
- ☐ Hope Haven of Northeast GA, Athens
- ☐ Avita Community Partners, Flowery Branch