FAX - REFERRAL FORM

PATIENT INFORMATION

☐ Fort Collins Fax to 970-207-9844

Patient's Name _____

Phone _____

Date of Birth _____

I hereby authorize you to have someone contact me to provide me with more information regarding low vision rehabilitation.

Patient's Signature _____ Date _____

DOCTORS INFORMATION

Doctor's name _____

Phone _____

Signature _____

Location _____

Please return this completed form to Ensight Skills Center at FAX # 970-207-9844 We will call your patient to explain low vision rehabilitation and our services.