



PATIENT REFERRAL FORM

Northern California Lions Sight Association
2750 – 24th Street, Sacramento, California 95818



VISION IS POSSIBLE PROGRAM

Patient's Name: _____ Birth Date: _____ Sex: Male/Female

Address: _____ Phone: _____
Street City State Zip

Name of responsible Adult: _____ Phone: _____
(Parent, Guardian, etc.)
Address: _____ City: _____ State: _____ Zip: _____

The Patient is being referred for the following reason(s) Diagnosis is: _____

Referring Physicians: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Signed: _____ M.D., O.D.

Note to Doctor:
Findings of complete eye examination including visual acuity, external, slit lamp, muscles and fundus would be helpful.

Sponsoring Lions Club: _____ VIP Member (NCLSA) Yes ___ No ___
Address: _____ City: _____ State: ___ Zip: _____
Please use address to which all correspondence on this patient is to be sent.

I verify that I have screened this patient with regard to his/her financial needs and have found that he/she is eligible for NCLSA Assistance:
Authorizing Signature of Club Representative: _____

Insurance Information: Policy name _____ Number: _____
Group: _____ Address: _____

DO NOT WRITE BELOW THIS LINE

Authorized Program Committee, NCLSA YES NO

Remarks: _____

Date service rendered: _____ NCLSA Director (signed) _____

FINANCIAL COSTS: Doctor \$ _____ Hospital \$ _____ Other: \$ _____

4 Copies 1st Doctor 2nd NCLSA 3rd NCLSA 4th Referring Lions Club