



PHYSICIAN REFERRAL FORM
Lions Eye Foundation of
California-Nevada, Inc.
PO Box 7999, San Francisco, CA 94120
Phone (415) 600-3950 Fax (415) 600-3949

TO SUBMIT APPLICATION:

Please include the following:

- _____ Completed Physician Referral Form
- _____ Completed Patient Financial Statement
- _____ Signed Patient Release of Information Form
- _____ Proof of Income
- _____ Medical exam notes and any tests related to eye condition

Mail: Lions Eye Foundation
PO Box 7999
San Francisco, CA 94120

or Fax: (415) 600-3949
Attn: Mark or Michelle

Note: Incomplete applications will delay the referral process

Date received: _____ Authorized by Screening Committee? Yes No Initial: _____

Questions? Please call (415) 600-3950

Date: _____

Referring Physician: _____

Phone: _____

Address: _____

Fax: _____

Street

City State Zip

Patient: _____

Birth date: _____ M F

Last First

Address: _____

Phone: _____

Street

City State Zip

Cell: _____

Language: _____

The patient is being referred for the following reason: No Insurance Limited Income

Diagnosis: (Please include complete eye exam, including visual acuity, external, slit lamps, muscles and fundus exams):

Signed: _____ MD / OD

Sponsoring Lions Club: _____ **District:** _____

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance:

Authorized by: _____
Print Name

Title: _____

Address: _____
Street

Phone: _____

City State Zip

Signature: _____

Date: _____

Note: All correspondence from Lions Eye Foundation will be sent to the address provided