



Lions Eye Foundation of California – Nevada, Inc.

2340 CLAY STREET, SAN FRANCISCO, CALIFORNIA 94115
TELEPHONE (415) 600-3950
MAILING ADDRESS: P.O. BOX 7999, SAN FRANCISCO, CA 94120

NOTE: DO NOT USE THIS FORM IF YOU ARE REFERRING A PATIENT WHO IS FINANCIALLY ABLE TO PAY FOR HIS CARE

PATIENT REFERRAL FORM

To: LIONS EYE FOUNDATION OF CALIFORNIA – NEVADA, INC. Date: _____

From: Dr. _____

Address: _____ Phone: _____
Street City State Zip

Patient's Name: _____ Birth date _____ Sex _____

Address: _____ Phone: _____
Street City State Zip

Name of responsible
Adult (parent, guardian, etc.) _____

Address: _____ Phone: _____
Street City State Zip

This patient is being referred for the following reason: _____

The diagnosis is: _____

Findings of complete eye exam, including visual acuity, external, slit lamp, muscles and fundus, would be most helpful.

Signed: _____ M.D./O.D.

Sponsoring Lions Club _____

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance. (Please **print** and sign your name to indicate you have screened the patient financially and have found him/her eligible for Foundation assistance.)

Authorized by _____ Title _____ Phone _____
Address _____

Insurance Information: _____
Policy Name, Numbers, etc

DO NOT WRITE BELOW THIS LINE

AUTHORIZED BY SCREENING COMMITTEE: YES ____ NO ____

Remarks: _____

Signed: _____

Chairman, Screening Committee, L.E.F.

HOSPITAL ADMISSION DATE: _____

Instructions to Clubs: Send the original and two copies of this form to the Lions Eye Foundation, P.O. Box 7999, San Francisco, CA 94120, for approval. When approved, the patient will be contacted and given an appointment and appropriate instructions.