PATIENT REFERRAL FORM

Northern California Lions Sight Association
730 Crow Creek Circle, Galt, GA 95632

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 Physician:_____ 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

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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 Updated: 1/12/2025 se