



at Deicke House
219 East Cole Avenue
Wheaton, IL 60187
P: 630-690-7115
F: 630-690-9037

FAX - REFERRAL FORM

PATIENT INFORMATION

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 _____

Address _____

Phone _____

Signature _____

Please return this completed form to
Karen Thomas, Director of Patient Services
at **FAX # 630-690-9037**.

We will call your patient to explain
low vision rehabilitation and our services.