Date ____/_____/_____

Svs. Club ___
Title 1 _____
Lions _____

APS NURSING DEPARTMENT
VISION CARE REFERRAL REQUEST

School _____
Nurse _____

Name_____ DOB_____ Student #_____
Grade_____

Father _____Mother _____ Work #_____
Home#_____

Service Request: Exam/Glasses____ Exam Only _____ Glasses Only ____

Snellen Results: Right_____ Left _____

Comments _____

_____

I WILL WEAR THE GLASSES PRESCRIBED! _____
(Student's Signature)

****

CONFIDENTIAL SOCIAL SERVICE DATA

****

Title I Participant: YES _____ NO _____ **(NURSE TO FILL OUT)**

Title I Teacher Initials: _____

Family Data: Adults_____ Children _____ DR_____

Monthly take home pay: $_____ OPT._____

Rent/house payment: $_____

Monthly payments: $_____ $_____ $_____
(Gas) (Elec.) (Phone)

$_____
(Other)

(OFFICE USE ONLY)

Health Plan or Insurance	YES ___	NO ___	DATE _____
Welfare	YES ___	NO ___	DR. _____
Medicaid	YES ___	NO ___	AMT. _____
UNMH eligible	YES ___	NO ___	
Indian Health eligible	YES ___	NO ___	DATE _____
Migrant eligible	YES ___	NO ___	OPT. _____
Vision Care referral last year:	YES ___	NO ___	AMT. _____
Care Provider: Lions:	YES ___	NO ___	
(if not LIONS) Doctor:	_____		FAMILY $_____EX
Optician:	_____		PAID $_____GL
Family agrees to pay:	$_____		

DATE REFERRAL COMPLETED:

_____

Revised 9-1-98