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FREE SERVICES FOR THE VISUALLY IMPAIRED AND BLIND

REFERRAL FORM

Please complete this form for yourself or for someone else, then email, mail or fax it to the Lighthouse.

Name of the person making the referral

Contact name: _____
Relationship to the referral: _____
Telephone: _____
Email address: _____
Mailing address: _____

Name of the person with the visual impairment

Name of the referral: _____
Age of the referral: _____
Person to contact if different
from the referral name: _____
Telephone: _____
Email address: _____
Mailing address: _____

Medical Information (if available)

Diagnosed eye condition: _____
Acuity: O.D.: _____ O.S.: _____ O.U.: _____
Peripheral field loss: Yes: _____ No: _____
Degree of field loss: _____

Recommended Lighthouse Services

- | | |
|--|--|
| <input type="checkbox"/> Assessment of Independent Living Skills | <input type="checkbox"/> Support Group |
| <input type="checkbox"/> Independent Living Skills Training | <input type="checkbox"/> Job Readiness/Vocational Services |
| <input type="checkbox"/> Orientation & Mobility Training | <input type="checkbox"/> Assistive Technology Training |
| <input type="checkbox"/> Counseling | (computers, etc.) |

The Mission at Lighthouse is to provide persons who are visually impaired the skills needed to achieve their maximum independence. Thank you for your support.