



Dear Potential Client,

Thank you for contacting Vision Rehabilitation Services. Since 1983, we have been teaching people who are visually impaired or blind how to adapt to their vision loss so that they may function independently in their environments.

Please follow these steps:

1. Fill out the enclosed application and return it in the pre-addressed envelope provided for you.
2. Please fill out the top portion and sign both doctor information and release forms. Give one form to your medical doctor and one form to your eye doctor. You can drop off, mail or fax these forms to your doctors; then the forms can be mailed or faxed directly to us from your doctors' offices.

In order to schedule a Low Vision Evaluation with us you need to have had a dilated eye examination within the past 2 years.

Once your paperwork has been received by our office we will call you to schedule your appointment. When you come to your appointment please make sure to bring any magnifiers, glasses, shades, or other aides you are currently using. Please feel free to call us with any questions or concerns at 770-432-7280.

Sincerely,

*Christa Villacorta*

Christa Villacorta

Client Services Coordinator

[cvillacorta@vrsga.org](mailto:cvillacorta@vrsga.org)

Vision Rehabilitation Services  
3830 South Cobb Drive, Suite 125 Smyrna, GA 30080  
Phone 770-432-7280 Fax 770-432-5457  
[www.vrsga.org](http://www.vrsga.org)



## Application for Services

Date:	
Last Name:	
First Name:	
Address:	
City:	
State:	
Zip:	
County:	
Home Phone:	
Cell Phone:	
Email:	
Date of Birth:	
Last 4 digits of SSN:	
*Gender	
*Race	
*Marital Status	

**\*Information is used solely for statistical data and kept confidential.**



Are you a veteran?	Yes	No
How did you hear about us?		

If you would like us to contact someone other than yourself to set up your appointment, please list below:

Name:	
Relationship:	
Address:	
City:	
State:	
Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	
Email:	
Preferred Appointment Time:	
Would you like to be added to our mailing list?:	Yes No



## Doctor Information

Optometrist's or Ophthalmologist's Name:	
Date of Last Visit:	
Address:	
City, State & Zip:	
Phone:	
Fax:	
Medical Doctor's Name:	
Date of Last Visit:	
Address:	
City, State & Zip:	
Phone:	
Fax:	



**For which services are you applying?**

Comprehensive Low Vision Evaluation:	
Computer Access Training:	
Activities of Daily Living Training:	
Safe & Independent Travel Skills Training:	
Orientation to home, workplace, store, etc.:	
Adjustment to Vision Loss Counseling:	
Peer Support Group:	
Other:	

How else may we be of service to you?

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In which city do you wish to be seen for your Low Vision Evaluation?

\_\_\_\_\_ Smyrna

\_\_\_\_\_ Rome



## Emergency Contact Information

Name:	
Relationship:	
Address:	
City:	
State:	
Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	

Applicant Signature: \_\_\_\_\_



## **About Vision Rehabilitation Services**

Vision Rehabilitation Services (VRS) teaches people who are visually impaired or blind how to function independently in their environments.

### **Low Vision Evaluation Information**

- The comprehensive Low Vision Evaluation is performed by a skilled optometrist specially trained in low vision.

### **Included with the comprehensive evaluation:**

- Two contacts with our Licensed Clinical Social Worker
- Demonstration of various devices that may enhance your ability to read and function independently
- Instructions in how to use any devices that you purchase

You may qualify for a program that could help cover the cost of the Low Vision Evaluation. Additionally, a sliding fee scale based on ability to pay is available. If a low vision device is prescribed by the doctor, there will be an additional fee based on the cost of the devices.

Eligible clients will not be denied vision rehabilitation services because of age, sex, religion, race, national origin or other disabilities.



## EYE DOCTOR Information & Release Form

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last 4 digits of SSN \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I am authorizing you to release to Vision Rehabilitation Services my patient record information.

**X** \_\_\_\_\_

\*\*\*\*\*

(This section to be completed by the Doctor)

**\* Please Complete This Form and Send a Copy of the Patient's Last 2 Comprehensive Exams. Please include their Visual Field results, if any.**

**Thank You!! \***

Visual Acuity	Without Correction	With Correction	Intraocular Tension	Field Loss (Y/N)
Right Eye				
Left Eye				

Spectacle RX	Sphere	Cylinder	Axis	Add
Right Eye				
Left Eye				

Diagnosis \_\_\_\_\_

Print Physician's Name \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Date \_\_\_\_\_



MEDICAL DOCTOR
Information & Release Form

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I am authorizing you to release my patient records to Vision Rehabilitation Services:

X \_\_\_\_\_

\*\*\*\*\*

(This section to be completed by the Doctor)

Please complete this form and send a copy of the patient's medication sheet along with any other information pertinent to their eye health. Thank you.

Please check all conditions that apply:

Table with 5 columns and 4 rows listing medical conditions: Diabetes, Heart Disease, Hypertension, Respiratory/Lung, Mental, Dementia, Parkinson's Disease, Neuropathy, Arthritis, Digestive Problems, Other, please explain.

Please explain any other conditions:

Patient Medications:

Surgeries:

Print Physician's Name

Signature:

Address, City, State & Zip:

Phone:

Fax:

Date:



## DIRECTIONS

Vision Rehabilitation Services is located between two Wade Ford dealerships and is directly across from the King Springs Shopping Plaza (look for Big Lots) on South Cobb Drive. You will see a covered bus stop and the green Smyrna Community Health Facility sign at the driveway entrance to our building. Look for the blue VRS sign. We are .2 miles north of King Springs Road.

### **From the North (GA 400)**

- Start out going South on GA 400
- Merge onto 1-285 West (exit 4B) toward Chattanooga/Birmingham
- Exit at South Cobb Drive (Exit 15/GA 280) making a Right turn at the end of the ramp
- Continue North on South Cobb Drive towards Marietta for about 3.3 miles
- At the top of the hill, turn Left to get to Vision Rehabilitation Services after the intersection at King Springs Road (QT station on the Right)

### **From the Northeast (I-85)**

- Start out going South on I-85
- Take the I-285 West bypass (exit 95B) towards Chattanooga/Birmingham
- Exit at South Cobb Drive (Exit 15/GA 280) making a Right turn at the end of the ramp
- Continue North on South Cobb Drive towards Marietta for about 3.3 miles
- At the top of the hill, turn Left to get to Vision Rehabilitation Services after the intersection at King Springs Road (QT station on the Right)

### **From the Northwest (I-75)**

- Start out going South on I-75 to Windy Hill (Exit 260) making a Right turn at the end of the ramp
- Continue West on Windy Hill Road towards Smyrna for about 2 miles
- Turn Left onto South Cobb Drive and continue for 1.5 miles
- Turn Right to get to Vision Rehabilitation Services after the intersection at Wisteria Lane/McCauley Road

### **From Atlanta (I-75)**

- Start out going North on I-75 towards Marietta
- Merge onto 1-285 West (exit 4B) towards Chattanooga/Birmingham
- Exit at South Cobb Drive (exit 15/GA280) making a Right turn at the end of the ramp
- Continue North on South Cobb Drive towards Marietta for about 3.3 miles
- At the top of the hill, turn Left to get to Vision Rehabilitation Services after the intersection at King Springs Road (QT station on the Right)

### **From Marietta (GA 280)**

- Starting South from Marietta (Delk Road/GA 280) becomes South Cobb Drive
- Continue on South Cobb Drive and Turn Right to get to Vision Rehabilitation Services after the intersection at Wisteria Lane/McCauley Road