



LIONS DISTRICT 26-M2 EYECARE COMMITTEE - SURGERY REFERRAL FORM



Referred by _____ Date _____
 Address _____ Telephone (____) _____
 City _____ State _____ Zipcode _____

PLEASE ANSWER ALL QUESTIONS

Name _____ Telephone (____) _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth: Month _____ Date _____ Year _____ Sex _____ Marital Status _____
(If applicant is less than 18 years of age, parent or guardian must complete and sign form.)

Last 4 of Social Security # _____ Driver's License # _____
 For Minor-Parent/Guardian Name _____ Relationship to Minor _____
 For Adult – Emergency Contact Name _____ Telephone (____) _____
 Brief Description on Problem _____

TOTAL MONTHLY INCOME

Wages _____
 Pension _____
 Unemployment _____
 Social Security/SSI _____
 Food Stamps _____
 Housing Allowance _____
 Other _____
TOTAL INCOME _____

TOTAL MONTHLY EXPENSES

Rent/Mortgage _____
 Gas & Electric _____
 Telephone _____
 Medical _____
 Clothing _____
 Food _____
 Other _____
TOTAL EXPENSES _____

Number of persons living in household _____

(Please attach copy of both sides of current Federal Income Tax Return (1040) and/or most recent Social Security Benefit Amount Notification Letter along with copy of any other monthly income.)

Is applicant covered by medical insurance? Yes _____ No _____ (If yes, supply information below.)
 Entitled to Medicaid? Yes _____ No _____ DCN # _____
 Entitled to Medicare? Yes _____ No _____ ID # _____
 Other Insurance: _____ Name of Insured if different from applicant: _____
 Has assistance from Government Agencies been sought? Yes _____ No _____ If yes, please list agencies applied to and determination of eligibility: _____ Attach copy of letters.

AGREEMENT

I understand that Lions Eyecare Committee will cover expenses for examination, treatment or surgery only after acceptance of referral. I certify that all the information above is correct and that deliberate misrepresentation may cause me to be declined for the applied aid. I acknowledge I have read and signed attached disclosure form.

Applicant's Signature _____ Date _____

Send Completed form to:

Lions EYECARE Committee
 1695 Valero Lane
 Fenton, MO 63026

FOR OFFICE USE ONLY:

Application Accepted: Yes _____ No _____
 Referred to: _____
 For Service/Exam _____
 CASE FILE # _____



LIONS DISTRICT 26-M2 EYECARE COMMITTEE

I, _____, hereby authorize the Lions District 26-M2 Eyecare Committee to release any information regarding my application for medical and financial history to the Lions Eyecare Committee members for their review, if so requested.

Also, Lions District 26-M2 Eyecare Committee, affiliated Lions Clubs and medical consultants are indefinitely released from all debts, claims and/or liability of any kind arising out of or in connection with the use or description of this informational material.

Applicant or Parent/Guardian Signature _____

Date _____

I give permission to the Lions Eyecare Committee to leave messages at my home or work containing information regarding appointments, surgeries, glasses, contacts, or results of medical testing.

Yes ____ No ____

I also give permission to discuss any of my personal or medical information to the person(s) listed below. If no names are listed, I understand that no information will be given other than the brief messages listed above. I have the right to change this decision at any time with written or verbal notice to Lions District 26-M2 Eyecare Committee.

Specific person(s) permitted to discuss detailed information.

Applicant or Parent/Guardian Signature _____

Date _____

CASE FILE # _____