|  |
| --- |
| MISSOURI DEPARTMENT OF SOCIAL SERVICESFAMILY SUPPORT DIVISION**OPHTHALMOLOGIST / OPTOMETRIST INFORMATION REQUEST** |
| INDIVIDUAL NAME (FIRST) | (MIDDLE) | (LAST) | INDIVIDUAL DCN | DATE OF BIRTH |
|       |       |       |       |       |
| **Instructions**: List all ophthalmologist(s) or optometrist(s) that have provided care or services to you within the last year (12 months). If needed use a separate sheet and attach to this form. |
|  |
|  | **Do you have an ophthalmologist or optometrist?** | **Yes** |  | **No** |  |  |  |
|  |  |  |  |
|  | **If yes, list their information below:** |  |  |
|  |  |  |  |
|  | Facility & Doctor Name/s: |       |  |
|  |  |  |  |
|  | Mailing Address:  |       |  |
|  |  |  |  |
|  | City: |       | State: |     | Zip Code: |       |  |
|  |  |  |  |  |  |  |  |
|  | Telephone number:  |       |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Date Last Seen: |       |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Any upcoming appointments? | Yes |  | **No** |  |  |  |
|  |  |  |  |  |
|  | If yes, date of appointment: |       |  |  |
|  |  |  |  |  |  |
|  | **Please list additional ophthalmologist or optometrist seen within the last 12 months:** |  |
|  |  |  |  |
|  | Facility & Doctor Name/s: |       |  |
|  |  |  |  |
|  | Mailing Address:  |       |  |
|  |  |  |  |  |  |  |  |
|  | City: |       | State: |     | Zip Code: |       |  |
|  |  |  |  |  |  |  |  |
|  | Telephone number:  |       |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Date Last Seen: |       |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Any upcoming appointments? | Yes |  | **No** |  |  |  |
|  |  |  |  |  |
|  | If yes, date of appointment: |       |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  | IM-61D OPTH | 08/2014 |  |