EnVision Independence Rehab Services

Low Vision Occupational Therapy Referral Form (Non-Optometry/Ophthalmology)

Patient Information:

Patient Name: _____
Phone Number: _____
Date of Birth: _____
Medical Diagnosis: _____
_____

Patient Address:
_____
_____

Visual Impairment ICD-10 Codes:
_____

With corrected vision does the patient report difficulties in any of the following areas:

- ☐ Reading
- ☐ Financial/medical management
- ☐ Completion of self-care tasks
- ☐ Driving
- ☐ Medication management
- ☐ Difficulties seeing steps/curbs
- ☐ Falls/loss of balance
- ☐ Meal preparation
- ☐ Reading for community management/shopping
- ☐ Seeing TV with accuracy
- ☐ Lighting/glare sensitivities

MARK ALL THAT APPLIES:

- ☐ **Occupational Therapy Low Vision Evaluation and Treatment**
- ☐ **Off-Road Drivers Assessment**

Physician Name: _____ **Date:** _____

Physicians Signature: _____ **NPI:** _____

Phone Number: _____ **Fax Number:** _____

PLEASE SEND THE FOLLOWING WITH THIS REFERRAL TO:
FAX: 724-320-0922

- **Patient's Insurance Cards**
- **Last Office Visit Note/Clinical Concerns**

Phone: 724-900-4633
Fax: 724-320-0922
Email: Info@EnVisionIndependence.com
www.EnVisionIndependence.com