EnVision Independence Rehab Services

Low Vision Occupational Therapy Referral Form

Patient Information:

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

Patient Address:
_____
_____
Visual Impairment ICD-10 Codes:
_____

	O.D.	O.S
Corrected Distance Acuity		
Corrected Near Acuity		
Current Prescription		
If applicable, Visual field loss		

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

- **Patients Insurance Cards**
- **Last Eye Exam**

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