CAROLINA
Low Vision Rehab

Physician Referral - Low Vision Rehabilitation

Patient Information:

Patient Name: _____ DOB: _____

Patient Phone #: _____

Caregiver Phone # (if applicable): _____

Patient Address: _____

Primary Insurance and Number: _____

Secondary Insurance and Number: _____

Medical Diagnosis: _____ Onset Date: _____

Physician Order:

☐ Occupational Therapy - Evaluate and treat as indicated.

Comments/Recommendations (refer to page 2 to indicate functional needs):

_____

→Physician Signature: _____ Date: _____

Physician Information:

Physician Name (print): _____

Physician NPI #: _____

Office Address: _____

Office Phone #: _____ Office Fax#: _____

Please complete the above information and FAX to Carolina Low Vision Rehab at 336-450-1931.

Please include a copy of the patient's last exam.

Indications for Low Vision Occupational Therapy

Does your patient have difficulty with…
☐ **Reading and/or Writing**
☐ **Using Prescribed Optical Devices**
☐ **Medication Management**
☐ **Chronic Disease Management**
☐ **Driving/Community Mobility**
☐ **Exploration/Use of Adaptive Equipment/Assistive Technology**
☐ **Safety/Emergency Response**
☐ **Frequent Falls**
☐ **Self-care/Personal Hygiene**
☐ **Self-feeding**
☐ **Meal Prep/Clean Up**
☐ **Shopping**
☐ **Housekeeping**
☐ **Leisure Exploration/Participation**
☐ **Social Participation**
☐ **Navigating the Home Environment**

Please check all that apply. Contact us at 336-414-8265 with questions.