Florida Vision Technology
solutions for visual independence

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Dear Doctor,

Your patient, _____, has met with one of our Assistive Technology Specialists. We determined that the patient would benefit from the use of one or more vision aids to improve their activities-of-daily-living. Daily activities may include reading, writing, cooking, shopping, grooming, managing medications, computer access, or handling personal finances.

Your patient has decided to purchase one or more low vision aids from **Florida Vision Technology**. We will train him/her to use the device properly, and periodically, we will check on their progress.

According to Florida law, we can EXEMPT your patient from paying state sales tax on their purchases **if we obtain a signed statement from their licensed physician or optometrist** (Medical Code #369.25). Your patient has requested such an exemption.

Please sign the RX form below and return it to us in the self-addressed envelope enclosed or fax to 954-462-4647. Please feel free to call me with any questions. Thank you for your assistance.

Sincerely,

Florida Vision Technology
cc: RX request form, brochure, business card, return envelope

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Patient name: _____

Patient address: _____

Contact information (phone/email): _____

Visual Acuity: _____ **Visual Field:** _____ **Visual Diagnosis:** _____

Technology Recommendation(s):_____

As a licensed Physician or Optometrist, I have examined the patient named above. I find that their optically-correctable vision is insufficient to allow normal activities-of-daily-living. Therefore, I prescribe the use of Low Vision Devices as necessary to assist with these activities.

_____ **Signature**

_____ **Print Name**

_____ **Practice Address**

_____ **Practice City, State, Zip**