OccuVision

Home Based Vision Rehabilitation Services

Physician Referral for Occupational Therapy Services

Client Information

Client Name: _____DOB: _____

Medical Dx (s): _____ ICD-10 (s):_____

Onset Date: _____

Address: _____

Client Phone Home: _____ Mobile: _____

Primary Insurance and Number: _____

Secondary Insurance and Number: _____

Please complete the "Client Information" section OR include a copy of the client's Facesheet and Insurance Cards

Physician Information

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Physician order: Occupational Therapy to evaluate and treat _____ (client's name) to address visual skills training.

Physician Signature: _____ Date: _____

Physician NPI #: _____

Physician Name Printed: _____

Please fax this order and a copy of the client's most recent exam to 1-844-646-0337