Vision Rehabilitation Services

Physician Referral for Occupational Therapy Services

Patient Information

Patient Name: ____DOB: _____________________

Medical Dx (s): ____________________________________ ICD-10 (s): ________________________

Address: ____

Patient Phone Home: __________________________________ Mobile: __________________________

Primary Insurance and Number: ____

Please include a copy of the patient's demographics, insurance cards, and a recent office visit note

Physician Information

Practice Name: ____

Phone: _________________________________ Fax: ____________________________________

Physician order: Occupational Therapy to evaluate and treat for visual impairments.

Physician Signature: ____ Date: ___________________

Physician NPI #: _______________________

Physician Name Printed: _______________________________

Please fax to us at 844-646-0337