



Order for Occupational Therapy Low Vision Services

Patient Name: _____

Address: _____

Phone: _____ DOB: _____

Referring Physician _____

Address: _____

Phone: _____ Fax: _____

Date of last exam: _____ Was this a Low Vision exam? YES NO

Diagnoses:

Dx 1:	Dx 2:
ICD-10 Code:	ICD-10 Code:
Dx 3:	Dx 4:
ICD-10 Code:	ICD-10 Code:

Distance Acuity			Near Acuity				
Best Corrected:		Yes	No	Best Corrected:		Yes	No
		OD	OS			OD	OS
Retinal Findings/Visual Field Testing (Please attach copies of maps/images & keys)							

Fields tested: (circle/highlight) Peripheral Central Testing Instrument: _____

Optics suggested or prescribed:

Current Eye Medications:

Other recommendations:

Insurance Information

Medicare Number: _____

Primary Insurance: _____

ID#: _____ **Group #:** _____

Subscriber Name: _____

DOB: _____ **Relationship to Client:** _____

* Please send a copy of the last office visit when submitting this referral, as this is required by some insurance providers.

With my signature, I authorize the above individual for occupational therapy low vision evaluation and treatment.

Signature: _____

Printed Name: _____

Date: _____

Fax completed form to WMU Unified Clinics: (269) 293-3357