Occupational Therapy Referral Form

Prescription: _____ Low Vision Occupational Therapy
Evaluate and Treat as needed

Diagnosis:

___ HS3.029 Amblyopia
___ H34.239 Branch Ret Artery Occl
___ H34.8320 Branch Ret Vein Occl
___ H25.9 Cataract
___ H17.9 Corneal Opacity
___ E11.319 Diabetic Retin (bkrnd)
___ E11.3599 Diabetic Retin (prolif)
___ H53.30 Disorder of vision/ binoc
___ H40.10 Glaucoma, open-angle
___ H35.3190 Macular Degen (dry)
___ H35.3290 Macular Degen (wet)
___ H35.81 Macular Edema
___ H31.019 Macular Scar
___ H47.219 Optical Nerve Atrophy
___ H35.52 Retinitis Pigmentosa

Other: _____

Compass Vision Therapy
Cape Coral, FL
Phone: (239) 379-0036
Fax: (239) 347-6995

Patient Name: _____
Phone: _____

Recommended Optical Devices:

Near_____
Distance_____
Hands-free_____
Computer/TV_____

Additional Instructions: _____
_____
_____

Physician Name: _____
Date: _____
Signature: _____