VISIONS OF Independence
Helping Low Vision Patients Gain Independence

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Visions of Independence Program Referral Form

Name of Patient_____ Last Visit_____

Address_____

City_____ Zip Code_____ DOB_____

Phone Number _____ Medicare or HMO # _____

Secondary Insurance_____ Secondary # _____

Best corrected vision	Please check Right Eye	Left Eye
Metamorphopsia		
Scotoma central area		
Generalized contraction or constriction		
Moderate visual acuity is **20/60 -1** or less		
Severe visual acuity is less than 20/160, or field is 20 degrees or less (counts fingers at 15 feet)		
Profound visual acuity is less than 20/400, or visual field is 10 degrees or less (counts fingers at 10 feet)		
Near-total visual acuity is less than 20/1000, or visual field is 5 degrees or less (counts fingers at 3 feet)		
Total no light perception		

	Right Eye	Left Eye
Diagnosis		
Acuity		
Field		

ICD-10 Diagnoses: _____ _____ _____ _____

Registered with Mass. Commission for the Blind or RI Division of Blind Services ☐ Yes ☐ No

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I, Dr. _____, (please print) believe that the patient named above has the potential for improvement in function and request an occupational therapy evaluation plus an initial treatment.

NPI Number _____ Phone _____ Fax _____

Signature _____ Date_____