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 # _____

Need for Occupational Therapy Treatment	Please check at least one
Home Safety Assessment	
Fall Risk	
Adaptive Equipment Assessment and Training	
Functional Activities Training (ADL/IADL Training)	
Energy Conservation Technique	

Diagnosis that would justify an occupational therapy evaluation (ICD-10) _____

I, Dr. _____, (please print) request an occupational therapy evaluation plus an initial treatment for the patient named above.

NPI Number _____ Phone _____ Fax _____

Signature _____ Date_____