EMPOWER
OCCUPATIONAL THERAPY

Ph: 512-352-9527 ▪ Fax: 512-661-2820 ▪ www.eyecanrehab.com
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Physician Referral for Low Vision Occupational Therapy

Patient Information

Name_____

Address_____

Home phone_____ **Cell phone**_____

DOB_____

Medical insurance: _____

***Please include copy of insurance card with referral form.**

Medical Information

Medical Diagnosis(es) / ICD10:_____

Uncorrected	**Corrected-Distance**	**Corrected-Near**
OD _____	**OD** _____	**OD**_____
OS_____	**OS**_____	**OS**_____

Visual Field Defect? Y / N

Please Describe: _____

Referring Information:

□ (please check) Occupational Therapy Evaluation and Treatment

Referring Physician: _____ **Date:**_____

NPI: _____
Additional Comments:
_____
_____

Please attach most recent examination findings and relevant patient history information and fax to: 512-661-2820