244 North Queen Street
Lancaster, PA 17603
Phone: (717) 205-4141
Fax: (717) 291-9183

REFERRAL FORM

Patient Information- Completed by Patient or Doctor

Patient's Name:_____DOB:_____

Street Address:_____City:_____

Zip: _____ Phone: _____

Primary Insurance:_____ Insurance ID#:_____

Secondary Insurance: _____ Insurance ID#:_____

Doctor Practice: _____ Eye Doctor: _____

Vision Information- Completed by Eye Care Provider

Diagnosis:_____ ICD-10 Diagnosis Codes:_____

Distance Acuity OD:_____OS:_____ Degree of usable Visual Field: OD_____OS_____

Date of Exam:_____ Prognosis: Stable _____Progressive _____

Under our program, a person is considered visually impaired and eligible for services if he/she has "a visual acuity with best correction of 20/70 in the better eye, or a significant loss of visual fields, or has a corresponding impeding functional limitation." Does this person meet the above definition as someone who is visually impaired? No: _____ Yes: _____

Doctor's Orders for Services

Type of Therapy	☒ Low Vision Occupational Therapy (1-2 x/week prn for up to 10 weeks)	
Physician Signature (No stamp signature, must be original)	**X**	Date

***** If possible, please attach copy of latest eye exam.**