1830 S Alma School Rd #131
Mesa, AZ 85210
480-924-8755

Please fax this form with patient insurance, demographics and last exam note to 480-854-1864

Referral for Low Vision Occupational Therapy

Patient Name: ____ Patient's Phone Number: ________________________

D.O.B. ________________ Date of last examination: ____________________Insurance carrier: _____________________

Primary Diagnosis (please circle one):

	Right Eye →	0 Normal	1 Mod. VI	2 Severe VI	3 Blindness	4 Blindness	5 Blindness
Left Eye ↓		20/60 or better	20/61 - 20/200	20/201-20/400	20/401-20/1200	20/1201-LPO	NLP
0 Normal	20/60 or better		H54.511A	H54.512A	H54.413A	H54.414A	H54.415A
1 Mod. VI	20/61 - 20/200	H54.52A1	H54.2X11	H54.2X21	H54.1131	H54.1141	H54.1151
2 Severe VI	20/201-20/400	H54.52A2	H54.2X12	H54.2X22	H54.1132	H54.1142	H54.1152
3 Blindness	20/401-20/1200	H54.42A3	H54.1213	H54.1223	H54.0X33	H54.0X43	H54.0X53
4 Blindness	20/1201-LPO	H54.42A4	H54.1214	H54.1224	H54.0X34	H54.0X44	H54.0X54
5 Blindness	NLP	H54.42A5	H54.1215	H54.1225	H54.0X35	H54.0X45	H54.0X55

Additional diagnoses and codes (Ocular Disease causing Low Vision, Field Defects, etc.):_________________________________

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Best Corrected Distance Acuity
OD: ___________ OS: ___________

Best Corrected Near Acuity
OD: __________ OS: ____________

Describe Visual Field Defects: ____

Additional Comments:____

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Physician Signature: ____ Date: ___________________

Reminder: An occupational therapy referral does not include refraction. To qualify for low vision OT insurance coverage, the patient must be 20/60 or worse in their better seeing eye or have a documented visual field defect - central or peripheral. Any questions please don't hesitate to call or email!