

Visions of Independence Program Referral Form

Name of Patient _____ Last Visit _____

Address _____

City _____ Zip Code _____ DOB _____

Phone Number _____ Medicare or HMO # _____

Best corrected vision	Please check	
	Right Eye	Left Eye
Metamorphosia		
Scotoma central area		
Generalized contraction or constriction		
Moderate visual acuity is <u>20/60 -1</u> 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		

Registered with Mass. Comm. Blind or RI Division of Blind Services Yes No

	Right Eye	Left Eye
Diagnosis		
Acuity		
Field		

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

NPI Number _____ Phone _____ Fax _____

Signature _____ Date _____