Visions of Independence
Helping Visually Impaired Elders 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 One
Home Safety Assessment	
Adaptive Equipment Assessment and Training	
Functional Activities Training (ADL/IADL Training)	
Energy Conservation Technique	

Diagnosis (ICD-9 code) _____________

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 an initial treatment.

NPI Number ______________________ Phone ____________________ Fax _____________________

Signature _________________________________ Date_________________