THE FRANK STEIN AND PAUL S. MAY CENTER FOR LOW VISION REHABILITATION

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LOW VISION REHABILITATION REFERRAL

Thank you for choosing to refer your patient to us. To start the referral process, **fax the following to 415-430-9748**:

1) This *completed* referral form
2) Recent patient notes, including test results/ imaging
3) HMO authorization (if applicable)

Once completed, **your patient may call 415-997-6521** to set up an appointment.

Provider Name: _____

Address/Zip: _____

(P): _____ **(F):** _____ **(E):** _____

Preferred Communication (highlight or circle): P | F | E

☐ **Referral for OT evaluation and treatment to address deficits in performance:**

- ☐ **Activities and daily living such as reading medication labels/ bills**
- ☐ **Safe mobility and navigation**
- ☐ **Community/ peer support**

Referring Diagnosis: **ICD-10:** _____

- ☐ **Macular Degeneration:** ☐ Dry ☐ Wet
- ☐ **Glaucoma**
- ☐ **Diabetic Retinopathy**
- ☐ **Retinitis Pigmentosa**
- ☐ **Other:** _____

Patient Name (Last, First): _____ **DOB:** _____

GENDER: M | F | OTHER: _____ **PHONE:** _____

HOME ADDRESS: _____

PRIMARY INSURED NAME (if other than patient): _____

MEDICARE: YES | NO **INSURANCE COMPANY (if other):** _____

INSURANCE #/ID: _____ **HMO:** YES | NO