



OCCUPATIONAL THERAPY LOW VISION REHABILITATION REFERRAL

350 Seymour Avenue, Derby, CT 06418
Phone 203-732-7445
Fax 203-732-7395

Patient Name: _____ DOB: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Patient Phone Number: _____

Prescribed Magnification Power: _____

Authorization for OT to Distribute 3x – 10x Stand or Handheld Magnifiers as needed:

(Signature)

Best Corrected Acuity:

- Near: Right (OD): _____ Left(OS): _____ Both(OU): _____
 Right(OD): _____ Left(OS): _____ Both(OU): _____

Scotoma: Please Describe: _____

Services As Checked:

- Occupational Therapy Evaluation & Treatment
- Skilling training in compensatory techniques to increase safety and independence in self-care, meal preparation, housekeeping and financial management.
- Skilled training in effective use of optical devices to compensate for low vision as needed for independent daily living.
- Skilled training in compensatory techniques to increase safety and independence in community activities.
- Educate patient/family on methods to increase safety and independence of patient in home/community.
- Other: _____

Frequency: _____ Duration: _____

Print Physician's name: _____

Physician's Tel: _____ Fax: _____

Physician Signature: _____ Date: _____