# HI Care Therapy

Phone: 808.501.0110
Fax: 808.204.2488
hicaretherapy.com

## Physician Referral for Low Vision Rehab Occupational Therapy

**First complete this form & include:**

- ☐ **Copy of client facesheet**
- ☐ **Copy of insurance cards**
- ☐ **Recent eye report**

**Please fax all items to: 808.204.2488**

**Client Name:** _____ **DOB:** _____
**Client Phone(s):** _____
**Client Address:** _____
**Visual Impairment ICD-10 Code(s):** _____
**Relevant Medical Dx(s):** _____
**Date of Onset:** _____

| | OD | OS | Comments |
|---|---|---|---|
| **Corrected Distance Acuity** | | | |
| **Corrected Near Acuity** | | | |
| **Visual Field Loss** | | | |

**Physician Practice & Name:** _____
**Office Address:** _____
**Office Phone:** _____
**Office Fax:** _____
**Physician NPI #:** _____

### Physician Order

☒ ***Occupational Therapy to Evaluate & Treat***

**Comments/Concerns/Contraind./Recs:**

_____

_____

**X Physician Signature:** _____ **Date:** _____