CCABVI Chester County Association for the Blind and Visually Impaired

OCCUPATIONAL THERAPY REFERRAL

Email: Colleen@chescoblind.org
Fax: (484) 657-7578; Phone: (610) 384-2767; ext. 103

Date:
Physician/Ophthalmologist/Optometrist:
Client Name:
Client DOB: **Phone:**
Client Address/zip code:
Diagnosis/ICD-10 Codes:
Vision Impairment Code:
Relevant Surgical Procedures: ***Additional documentation and notes regarding the patient's eye care condition are appreciated***   **Medical History:**
Precautions/Allergies:
Medications:
Insurance: (Name of plan/ID number) Primary: **Secondary:**
cc sc (circle one) DVA: _____OD _____ OS _____OU   **RX:**
cc sc (circle one) NVA: _____OD _____ OS _____OU   **RX:**
Field: _____OD _____OS   **Contrast: _____OD _____OS**
Legally Blind: _____YES _____NO
Optical Device(s) Recommended:
Chief Complaint/Reason for Referral:
Occupational Therapy Services: **_X_ Evaluation** (97165,97166,97167) ; __Reevaluation (97168);   __Therapeutic exercises (97110); __Neuromuscular Reeducation (97112);__Therapeutic activities (97530);   __ Sensory integrative techniques (97533);**_X_ Self-care/home management training (97535)**   __ Community/reintegration training (97537)

X Frequency/duration: 1 x wk. or every other Wk. x 8-10 wks.

Physician Signature: **Date:**

****Please sign and fax to CCABVI at (484) 657-7578 ATTN: Colleen McVeigh, OTR/L**