VISION REHAB CENTER
A Division of Vision Resources of Central Pennsylvania

Low Vision Occupational Therapy Referral

Patient Name:_____Patient DOB: _____

Patient Phone Number:_____Date of last eye exam:_____

Patient Address: _____ City: _____Zip Code _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Reason for Referral: ☐ Reading/Writing ☐ Activities of Daily Living ☐ Other: _____

Visual Acuity:

Primary Gaze	Best Corrected	Eccentric Viewing Pattern (if known)
OD_____	OD_____	OD_____
OS_____	OS _____	OS_____

Date of most recent glasses prescription if known: _____

It is recommended the following items be assessed/addressed with the client (select all that apply):

☐ Near Magnification
Recommended Strength: _____
*****If undetermined, please select one or more strengths to trial with the client
☐ 2.5x – 3x ☐ 3.5x – 4x ☐ 5x – 6x ☐ 7x ☐ Other: _____

☐ Digital Magnification

☐ Distance Magnification/Telescope
Recommended Strength: _____
*****If undetermined, please select one or more strengths to trial with the client
☐ 2.5x - 4x ☐ 5x - 6x ☐ 8x - 10x ☐ Other: _____

☐ Lighting

☐ Tints/blue blockers

☐ Home evaluation/home adaptations

☐ Other:

A low vision occupational therapy evaluation and treatment is recommended to address ADL/I-ADL dysfunction secondary to visual impairment.

Name of Referring Physician: _____

Physician Signature:_____Date of Referral: _____

Referring Physician Phone:_____Fax: _____

Please include a copy of the client's most recent eye exam results with your faxed referral.
The completed occupational therapy reports will be faxed for your review and signature.

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