LIGHTHOUSE
LOUISIANA

Vision Rehabilitation Services

Physician Referral

PATIENT INFORMATION

Patient Name: _____ Age: _____ D.O.B. _____

Home Phone: _____ Cell Phone: _____ Date of last visit: _____

Primary Visual Diagnosis: _____

ICD-10 Code: _____

Best Corrected Visual Acuity	OD	OS	Visual Fields	OD	OS
Best Near			Peripheral		
Best Distance			Central		
IOP			Cataracts	(Yes/No)	(Yes/No)

Current Eye Glass Prescription	OD	OS

PHYSICIAN INFORMATION

Referring Physician: _____ NPI: _____

☐ Ophthalmologist ☐ Optometrist ☐ Neurologist ☐ Internist ☐ Other: _____

Name of Clinic: _____

Physician Phone #: _____ Physician Fax #: _____

It is my recommendation for the patient to receive Occupational Therapy to evaluate and treat for Visual Rehabilitation.

_____ _____

Physician's Signature Date of Referral

Please email to: lvc@lighthouselouisiana.org or fax: 504-613-4850
Phone #: 504-899-4501 ext. 238

Thank you for your referral to Lighthouse Louisiana.
For more information about our services, visit www.LighthouseLouisiana.org.