

Physician's Orders

Patient Information:
Date: _____

Name: _____ **D.O.B.:** _____ **Phone #:** _____

Address: _____ **County:** _____

Insurance: *(Please send copy of insurance cards with order):* _____

Referring Doctor: _____ **Date of Last Exam:** _____

BCVA:	OD 20/ OS 20/
Visual Fields:	OD OS
ICD 10 LV Impairment code (if known): _____	

Please circle additional impairment code(s) as needed:

H53.40	Visual Field Defect
H53.41 (1 2 3) (Circle One)	Central Scotoma
H53.45 (1 2 3) (Circle One)	Ring Scotoma
H53.48 (1 2 3) (Circle One)	Constriction by Eye, Generalized
H53.46 (1 2) (Circle One)	Bilat Homonymous
H53.47	Bilat Heteronymous
By Eye: 1=right, 2=left, 3=both	

Please circle & complete digits 6 & 7 for AMD & Glaucoma diagnosis code(s): Digit 6 = eye (1/right, 2/left, 3/both) Digit 7 = Severity

H35.31__	Mac Degen-Nonexudative	H40.11__	Glaucoma (POA)	Diabetes	Add 5th, 6th, & 7th digit #'s to diabetic codes
H35.31__	Mac Degen - Nonexudative	H40.11__	Glaucoma (POA)	5th Digit	2(mild) 3(mod) 4(severe)
SEVERITY		H40.22__	Glaucoma-Chronic Angle	6th Digit	1(w/ME) 9(w/o ME)
1	Early Dry	H40.22__	Glaucoma-Chronic Angle	7th Digit	1(OD) 2(OS) 3(OU)
2	Intermediate Dry				
3	Adv Atrophic w/o Subfoveal Inv	Severity	1 (Mild) 2 (Moderate)	E10.3__	Type 1 DM NPDR
4	Adv Atrophic w/Subfoveal Inv		3 (Severe) 4 (Indeterminate)	E11.3__	Type 2 DM NPDR
H35.32__	Mac Degen-Exudative				
H35.32__	Mac Degen-Exudative	H47.20	Optic Atrophy, Unspec	E10.351__	Type 1 DM PDR w/ME
SEVERITY		I69.998	CVA	E10.359__	Type 1 DM PDR w/o ME
1	W/Active Chroidal Neovasc	H35.52	Retinitis Pigmentosa	E11.351__	Type 2 DM PDR w/ME
2	W/Inactive Chroidal Neovasc			E11.359__	Type 2 DM PDR w/o ME
3	W/Inactive Scar		Other:		Other:

Treatment Plan: Orders for Services: (recommendations)

- Occupational Therapy - Evaluation and Treatment for Vision Rehabilitation
- Independent Living Skills Training (ILST) / Serving Our Seniors (SOS): ADL's, Money Management, Cooking, Marking Appliances
- Orientation & Mobility (O & M)
- Assistive Technology (E-reader, computer, smart phone training)

Devices Recommended _____

 Are you aware of any contraindications to any treatment modalities? YES NO

 Rehab Potential: Excellent Good Fair Poor

Please attach any current findings or past medical history to assist in the coordination of care for your patient.

Comments: _____

 Physician Signature

 Date