



# RUSK INSTITUTE of Rehabilitation Medicine

## REFERRAL FOR OUTPATIENT OT VISUAL SKILLS RETRAINING

**FAX to the RUSK BUSINESS OFFICE (212) 263-0113**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Patient Social Security Number: \_\_\_\_\_

Patient Telephone Number: Contact 1: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Contact 2: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Patient Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Insured Name: \_\_\_\_\_

**Medical Diagnosis:** \_\_\_\_\_

\_\_\_\_ Visual Disturbance 368.10

\_\_\_\_ Visuospatial Neglect 781.8

\_\_\_\_ Lack of Coordination 781.3

\_\_\_\_ Homonymous Hemianopsia 368.46

\_\_\_\_ Multiple Sclerosis 340.0

**ICD 9:** \_\_\_\_\_

\_\_\_\_ CVA 436

\_\_\_\_ Vertigo 780.4

\_\_\_\_ Diplopia 368.2

\_\_\_\_ Brain Injury 854.00

\_\_\_\_ Other \_\_\_\_\_

Onset Date: \_\_\_\_\_

**Prescription for: (please select)**

\_\_\_\_ Novavision Evaluation

\_\_\_\_ Novavision Treatment

\_\_\_\_ Vision Skills Evaluation

\_\_\_\_ ADL Retraining

\_\_\_\_ Home Management

\_\_\_\_ Therapeutic Exercise

\_\_\_\_ Sensory Integration

\_\_\_\_ Therapeutic Activity

\_\_\_\_ Community Reintegration

Physician Order Frequency and Durations: \_\_\_\_\_ (times/week) \_\_\_\_\_ (number of months)

Physician's Name: \_\_\_\_\_

License Number: \_\_\_\_\_ UPIN: \_\_\_\_\_ NPI# \_\_\_\_\_

Office Telephone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

