



A trade name for Arizona Low Vision Occupational Therapy PLC

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____
Patient Phone: _____
Patient Address: _____
Primary Insurance & ID: _____
Secondary Insurance & ID: _____

ICD 10 & DIAGNOSIS:

Physician Order

☐ Occupational Therapy: Evaluate and treat as indicated.

Comments/Recommendations:

Physician Signature: _____

Provider Information:

Provider Name: _____ Provider NPI: _____
Office Address: _____
Office Phone: _____ Office Fax: _____

INDICATIONS FOR LOW VISION OCCUPATIONAL THERAPY

- | | |
|---|---|
| ☐ Reading and/or Writing | ☐ Using Prescribed Optical Devices |
| ☐ Medication Management | ☐ Meal Prep/Clean Up |
| ☐ Housekeeping | ☐ Shopping |
| ☐ Safety/Emergency Response | ☐ Frequent Falls |
| ☐ Self-Care/Personal Hygiene | ☐ Self-Feeding |
| ☐ Driving/Community Mobility | ☐ Exploration/Use of Adaptive Equipment/Assistive Technology |

Please complete the above information and FAX to Tandem Low Vision at 480-461-9312

Contact us at 602-233-7420 with questions.

Please include a copy of the patient's last exam & insurance card.