Physician's Orders

ENVISION™

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	H47.213	Optic Atrophy, Primary	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: Standing Orders for Services:

☐ Occupational Therapy - Evaluation and Treatment for Vision Rehabilitation

☐ Physical Therapy - Evaluation and Treatment for (balance, fall risk, vestibular, etc.)_____

☐ Orientation & Mobility (O & M) ☐ Assistive Technology (tablet, computer, smart phone training, etc.)

Specific Devices Recommendations_____

I agree with recommendations for adaptive aid equipment determined by low vision rehabilitation staff based on patient testing and clinical reasoning, in lieu of written prescription.

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**

610 N. Main St. • Wichita, KS • 67203 • 316.440.1600 • Fax 316.440.1675