Physician's Orders

ENVISION DALLAS

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

☐ 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

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