



Ambulatory Care Center  
 Rusk Rehabilitation – Occupational Therapy  
 240 East 38th Street 17<sup>th</sup> Floor  
 New York, NY 10016  
[www.nyulmc.org/rusk](http://www.nyulmc.org/rusk)

**Occupational  
 Therapy  
 Vision Rehabilitation  
 Referral**

**OCCUPATIONAL THERAPY- VISION REHABILITATION**  
 FAX to (212) 263-0113 OR EMAIL [ACCRuskIntake@nyumc.org](mailto:ACCRuskIntake@nyumc.org)

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

Gender:  Female  Male Date of Birth: \_\_\_\_\_

Telephone Number: Home: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_

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**Medical Diagnosis:** \_\_\_\_\_ **ICD 10:** \_\_\_\_\_ **Onset Date:** \_\_\_\_\_

**OT Prescription for: (please select)**

- \_\_\_\_\_ OT Visual Skills Evaluation and Retraining \_\_\_\_\_
- \_\_\_\_\_ ADL (Self Care Management Training) \_\_\_\_\_
- \_\_\_\_\_ Therapeutic Exercises and Activities \_\_\_\_\_
- \_\_\_\_\_ Community/Work Reintegration \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

**Physician Order Frequency and Duration:** \_\_\_\_\_

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**Physician's Name (Please Print):** \_\_\_\_\_

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

**Office Telephone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Office Fax:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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