Vision Referral Form

Box must be filled out completely by the person attending with member.

Member Name: ______________________________ **Date of Appt:** ____________

Name of Practice: ___________________________ **Time of Appt:** ____________

Doctor's Name: ____

Residential Provider/Staff Present: ____

□ **Pharmacy Verification:** ____

Diagnosis:

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Treatment Orders:

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□ **Generic equivalent acceptable**

Provider Signature ____

Next appt. scheduled for: Date: _________ **Time:** ______ **In Therap** □

Per Medicaid standards, all medication orders need to include:
Name, Dosage (cannot be a range), Form, Route, Time (cannot be a range)
Order example:
Cephalexin 500mg tablet. Take 1 tablet by mouth every 6 hours for 7 days.

Independent PCA ONLY:
Weight: _____ lbs. BP ____/_____ Other Vitals: __________ In Therap □