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:

_____

_____

_____

Treatment Orders:

_____

_____

_____

_____

_____

□ Generic equivalent acceptable

Medical 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.