L.A.B. COMMUNITY SERVICES
a division of Louisiana Association for the Blind

1714 CLAIBORNE AVE.
SHREVEPORT, LA 71103
318.698.2300
FAX: 1.888.990.0751

WWW.LABLIND.COM

Home Health Physician Referral

Patient Name: _____ Age: _____ D.O.B. _____

Home Phone: _____ Cell Phone: _____ Referral Date: _____

Alternate Contact Name and Number: _____

Insurance Information (*or attach copy)*: _____

Diagnosis/Medical Condition: (*List the diagnosis/medical conditions that are the primary reason the patient requires home health care.*)

_____

_____

Occupational Therapy—Assessments/Intervention Services: (*Ex. safety & fall risk, assistive technology training, medication mgmt., etc.)*

_____

_____

Referring Physician: _____

Name of Clinic: _____

Phone: _____Fax: _____

I recommend the patient receive low vision home health services to assess and address their visual rehabilitation needs, promoting greater independence and enhancing daily living skills.

_____ _____

Physician Signature Date of Referral

Please email to Kaleigh Malmay at kmalmay@lablind.com or fax 1-888-990-0751

Thank you for your referral to Louisiana Association for the Blind.