NORTHWEST eyedesign

OCULARISTS
Todd Cranmore, BCO BADO
Christie Erickson, BCO BADO
Tawnya Cranmore, Apprentice

Thank you for your referral!

Please complete the forms below and send with recent chart notes!

Patient Information

First Name	Last Name	Date of Birth
Parent/Guardian Name (if any)		
Phone		Email

Referring Office Information

Physician	
Office Contact	Email
Phone	Fax

Thank you and we appreciate the opportunity to share in the care of your patient!

Please send forms and chart notes to

referral@nweyedesign.com

Fax 425-823-1522

NORTHWEST eyedesign

OCULARISTS
Todd Cranmore, BCO BADO
Christie Erickson, BCO BADO
Tawnya Cranmore, Apprentice

_____ _____/_____/_____
Patient Name DOB

This is a written prescription for the services the above mentioned patient requires.

___ L9900 (Orthotic and Prosthetic Supply, Accessory)
___ V2623 (Custom Ocular Prosthesis)
___ V2624 (Orbital Exam and Polish)
___ V2625 (Enlargement of Ocular Prosthesis)
___ V2626 (Reduction of Ocular Prosthesis)
___ V2627 (Custom Scleral Shell)
___ V2628 (Fitting and Fabrication)
___ V2629 (Prosthetic Eye, Other Type)
_X_ All of the services above for lifetime care of the patient's prosthesis or shell

Diagnosis: ICD-10:Z44.21 & Z44.22

The above mentioned patient is in need of a prosthesis due to absence or shrinkage of their eye due to birth defect, trauma, or surgical removal. An ocular prosthesis restores the patient's orbit to normal volume and shape, so body functions about the orbit return to normal. The anophthalmic globe will atrophy when not functional. The prosthesis fills both the superior and inferior fornix so a proper flushing of the mucosal fluids will occur. The eye volume is necessary to properly exercise the muscles and orbital contents so there is no atrophy of the anatomical structure throughout the orbit. The purpose of an orbital exam and polish is to help keep protein deposits and bacteria from building on their prosthesis, preventing infection and damage to the prosthetic surface.

I certify the medical necessity of these items for this patient. This form and any statement attached is completed by or reviewed by me.

_____ _____/_____/_____
Physician Signature Date

_____
Printed Name