Date: [Insert Date]

To: [Recipient Name/Organization]
From: [Physician Name, MD/OD]
Patient Name: [Patient Full Name]
Date of Birth: [DOB]

Subject: Medical Necessity for Low Vision Rehabilitation

To Whom It May Concern,

This letter is to certify that [Patient Name] is currently under my care for advanced complications related to Diabetic Retinopathy. The patient has been diagnosed with [Specific Diagnosis, e.g., Proliferative Diabetic Retinopathy and Macular Edema], which has resulted in significant and permanent vision loss.

Current Clinical Status:
- Best Corrected Visual Acuity: OD [Right Eye] / OS [Left Eye]
- Visual Field Deficits: [Describe, e.g., central scotomas or peripheral loss]
- Functional Limitations: Significant impairment in reading, mobility, and activities of daily living.

Due to the advanced nature of this condition, standard corrective lenses and surgical interventions are no longer sufficient to restore functional vision. Therefore, I am referring this patient for comprehensive Low Vision Rehabilitation.

The requested rehabilitation program should include:

- Functional vision assessment.
- Evaluation and training for optical and electronic magnification devices.
- Orientation and Mobility (O&M) training for safe navigation.
- Adaptive technology training for vocational or independent living needs.

These services are medically necessary to maximize the patient's remaining vision and ensure their safety and independence. Please provide the necessary coverage and support for these essential services.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic Contact Information]