

## OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

**REFERRAL TO: Family Vision Development Center, PC for  
Pediatrics, Neuro-Rehabilitation, and Vision Therapies.**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**I am referring the above patient to your office for the following reasons:**

- |  |  |
|--|--|
| <input type="checkbox"/> Eye Strain/Headaches    | <input type="checkbox"/> Sports Vision Evaluation                        |
| <input type="checkbox"/> Reading/TV/Computer use | <input type="checkbox"/> Infant/preschool Evaluation                     |
| <input type="checkbox"/> Strabismus/Amblyopia    | <input type="checkbox"/> Post trauma/Stroke Evaluation                   |
| <input type="checkbox"/> Fluctuating Acuity      | <input type="checkbox"/> Accommodative Dysfunction                       |
| <input type="checkbox"/> Developmental Delays    | <input type="checkbox"/> Exophoria/Esophoria/Hyperphoria                 |
| <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Perceptual Evaluation (Poor School Performance) |

Eyeglasses RX: OD \_\_\_\_\_  
OS \_\_\_\_\_

Additional Information: \_\_\_\_\_

**REFERRAL FROM:**

DOCTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**The Family Vision Development Center, PC will recommend that the patient return to your office for all of their spectacle and contact lens needs.**