

Vision Therapy Referral Form

From the office of (please include clinic name and phone number below):

Type of developmental vision care requested:

- Consult and render opinion only.
- Evaluation and subsequent care if needed.
- Other: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Code (optional): _____

Parent/Guardian Name: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Phone (day): _____

Today's date _____ Referring Professional: _____

Check all conditions that apply or are in question:

- | | |
|--|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Lower 1/3 of class |
| <input type="checkbox"/> Asthenopia/visual fatigue | <input type="checkbox"/> Reading/learning problems |
| <input type="checkbox"/> Diplopia | <input type="checkbox"/> "Just not doing as well as he/she should" |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> "Good student who wants to do better work" |
| <input type="checkbox"/> Reduced acuity/amblyopia | <input type="checkbox"/> Good student who takes too long to complete homework |
| <input type="checkbox"/> Convergence insufficiency | <input type="checkbox"/> Special needs (Autism, C.P., AD(H)D, deaf, low vision) |
| <input type="checkbox"/> Unsure of responses/Streff Syndrome | <input type="checkbox"/> Infant/toddler |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Toddler/preschool delayed development |

Yes No Visual Fields have been completed on the patient

Yes No Dilated Fundus exam was within normal limits

Pertinent Diagnostic Findings and Comments:

Tech/Staff (signature)

Doctor (signature)

Please call Dr. Metzger's office at 913-468-8686 to schedule this patient for a developmental vision evaluation. Please leave a message, if necessary. Also, FAX this REFERRAL FORM and the patient's current VISION RECORDS to 913-469-8688.

Thank you for allowing Dr. Metzger to share in your patient's vision care. A report will be sent to your office at the completion of services.