GENERAL OPTOMETRY CHILDREN VISION VISION THERAPY CONTACT LENS SPORTS VISION

REFERRAL FOR A FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION

TO: Optometric Center for Family Vision Care and Vision Therapy Date: _____

Introducing: _____ _____
Patient Name Date of Birth

_____
Parent (or Guardian) Names

_____
Address City State Zip Code

_____
Home phone Work Phone Cell Phone

I am referring the above patient to your office for the following reason(s):

- ❑ School Problem
- ❑ Strabismus
- ❑ Visual Perceptual Problems
- ❑ Difficulty with Close Work
- ❑ Letter Reversals
- ❑ Other:_____
- ❑ Visual Discomfort/Headaches
- ❑ Amblyopia
- ❑ Developmental Delay
- ❑ Tracking Problems
- ❑ Eye-Hand Coordination Problems
- ❑ Post Trauma/Stroke Evaluation
- ❑ Computer Strain
- ❑ Attention Problems
- ❑ Head Movement while Reading
- ❑ Head Tilt

FROM: _____
Referred by

_____
Address City State Zip Code

_____
Email address Telephone

I authorize the disclosure and sharing of medical and/or educational information between the above party and doctors and staff at Family Vision Care and Vision Therapy.

_____ _____
Patient/Parent (Guardian) Signature Date

PLEASE FAX A COPY OF THIS FORM TO OUR OFFICE AT 650.595.5203
WE WILL CONTACT THE REFERRED PATIENT ASAP

OPTOMETRIC FOR FAMILY VISION CARE AND VISION THERAPY

CAROLE L. HONG, OD, FCOVD JULIE KIM, OD JUSTINE SIMON, OD SURBHI BANSAL, OD, FAAO, FCOVD

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