**CAROLE L. HONG, OD, FCOVD ♦ JULIE KIM, OD ♦ JUSTINE SIMON, OD ♦ SURBHI BANSAL, OD, FAAO, FCOVD**
OPTOMETRIC CENTER FOR FAMILY VISION CARE & VISION THERAPY
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# REFERRAL FOR A FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION

*Fax to:* 650.595.5203

Date

Referred By

Address

City State Zip

Area Code Phone Best time to call

Patient's Name Age Date of Birth

Contact Information: Parent's Name

Address

City State Zip

Area Code Phone Best time to call

**Reason(s) for Referral:**

- ☐ Binocular Vision Disorder
- ☐ Accommodative Difficulties
- ☐ Strabismus/Amblyopia
- ☐ Visual Perceptual Problems
- ☐ Problems with Attention
- ☐ Visual Discomfort/Headaches
- ☐ Double Vision
- ☐ Convergence Insufficiency/Excess
- ☐ Poor Handwriting
- ☐ Developmental Delays
- ☐ Post Trauma/Stroke Evaluation
- ☐ Eye Strain or Headaches
- ☐ Loss of Place when Reading
- ☐ Trouble Copying from Board
- ☐ Other:_____

**Results of Examination:**

Refraction: ☐ Wet ☐ Dry

OD_____ VA OD_____ SRx OD_____

OS_____ VA OS_____ SRx OS_____

*(if given)*

☐ DFE performed – no ocular health abnormalities noted Other: _____

Additional information: _____

**ATTENTION:**

**PATIENT & REFERRING DOCTOR – PLEASE READ PARAGRAPH BELOW AND SIGN ON THE LINE:**

I hereby grant permission for Drs. Hong, Kim, Simon or Bansal and any other professional involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I also hereby give permission to have this information faxed to Drs. Hong, Kim, Simon, or Bansal so that their office can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor) Date

***A copy of all tests results and a report will be sent to the referring doctor.***
***Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.***