FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION
FAX REFERRAL FORM
***Fax to:* 650.595.5203**

Date

Referred By

Address

City State Zip

Phone/Best Day/ Time to call Email

Patient's Name Age Date of Birth

Parent's Name if applicable

Address

City State Zip

Phone/Best time to call Email

Reason(s) for Referral:

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

Results of Examination:

Refraction: ☐ Wet ☐ Dry

OD_____ VA OD_____ SRx OD_____

OS_____ VA OS_____ SRx OS_____

(if given)

☐ DFE performed – Any ocular health abnormalities noted: _____

Additional information/testing performed _____

ATTENTION: PATIENT & REFERRING DOCTOR – PLEASE READ PARAGRAPH BELOW AND SIGN ON THE LINE:
I hereby grant permission for the Optometric Center for Family Vision Care & Vision Therapy 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 the Optometric Center for Family Vision Care & Vision Therapy 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.

OPTOMETRIC CENTER FOR FAMILY VISION CARE & VISION THERAPY
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