

# CHARRON

## VISION THERAPY

### Visual Evaluation Referral Form

Referring Provider: \_\_\_\_\_ Facility Phone: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guardian Full Name: \_\_\_\_\_ Best Phone: \_\_\_\_\_

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

\_\_\_\_\_

### Diagnosis/Reason(s) For Referral

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Visual Perceptual Problems | <input type="checkbox"/> Visual Discomfort/Headaches    | <input type="checkbox"/> TBI/Stroke Evaluation       |
| <input type="checkbox"/> Difficulty with Close Work | <input type="checkbox"/> Amblyopia/"Lazy Eye"           | <input type="checkbox"/> Concussion                  |
| <input type="checkbox"/> Letter Reversals           | <input type="checkbox"/> Developmental Delays           | <input type="checkbox"/> Attention - ADD/ADHD        |
| <input type="checkbox"/> Autism Spectrum Disorder   | <input type="checkbox"/> Tracking Problems              | <input type="checkbox"/> Head Movement while Reading |
| <input type="checkbox"/> Learning Problem           | <input type="checkbox"/> Eye-Hand Coordination Problems | <input type="checkbox"/> Vestibular Problems         |
| <input type="checkbox"/> Strabismus/Eye Turn        | <input type="checkbox"/> Visual Motor Dysfunction       | <input type="checkbox"/> Other: _____                |

Pertinent Symptoms/History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***\*\*A copy of all tests results and/or a report will be sent to the referring doctor.***

***\*\*Patients will return to referring doctor e and eyeglass prescriptions***

#### **CHARRON VISION THERAPY**

1151 ELLIS ST. #103 BELLINGHAM WA 98225

BELLINGHAMOPTOMETRY.COM T: (360) 393 4479 F: (360) 746 8661