CHARRON VISION THERAPY

Visual Evaluation Referral Form

Referring Provider:____

Clinic Name: _____________________________ Clinic Phone:______________________________ Clinic Fax:_______________________________

Patient Name:___________________________ Guardian(s) Name:___________________________ Patient Phone:___________________________

Patient Address:____

Diagnoses or Reason(s) for referral:

□ Strabismus/Eye Turn
□ Amblyopia/Lazy Eye
□ Learning Problem
□ Visual Perceptual Problems
□ Difficulty with close work
□ Visual Discomfort/Headaches
□ Letter Reversals
□ Developmental Delays
□ Eye Tracking Problems
□ Eye-Hand Coordination Problems
□ TBI/Concussion
□ Attention/Focus Problems
□ Balance/Dizziness
□ Diplopia
□ Autism Spectrum

Comments:____

____

____

Refraction: **Spec. / CL Rx. Given?** □ **Yes** □ **No**

OD:____ 20/_____

OS:____ 20/_____

□ **Ocular health was examined. No ocular abnormalities** □ **Other**_________________________

____

Testing recommended by referring doctor:

□ **Refraction:** *(includes binocular/accomm. tests)*
□ **Sensorimotor Evaluation:** *(includes oculomotor, strabismus, amblyopia, and suppression tests)*
□ **Visual Performance Tests:** *(includes other tests pertaining to academics/workplace: DEM, visual memory, eye-hand coordination/handwriting, perceptual, tests for reversals etc.)*
□ **To be determined at evaluation**

PLEASE FAX THIS FORM TO 360 746 8661

***A copy of all tests results and/or 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.*

CHARRON VISION THERAPY
1151 ELLIS ST. #103 BELLINGHAM WA 98225
BELLINGHAMOPTOMETRY.COM T: (360) 393 4479 F: (360) 746 8661