Hope | VISION DEVELOPMENT CENTER

VISION THERAPY REFERRAL

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Referring Educator: _____

Name: _____ DOB: _____

Phone: _____ Email: _____

Parent/Guardian (if patient is a child): _____

Pertinent Visual Signs/Symptoms/Exam Findings/Reason for referral: (check all that apply)

- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Eye Fatigue/Strain
- ☐ Headaches
- ☐ Headaches with near work
- ☐ Learning Related Problems
- ☐ Decreased Attention/Concentration
- ☐ Poor Reading Speed/Fluency/Accuracy
- ☐ Eye Tracking Difficulties
- ☐ Eye Teaming Difficulties
- ☐ Post Trauma / Head Injury
- ☐ Other: _____

Current Grade: _____ **Did the student repeat any grade?** ☐ **Yes** ☐ **No**

What subjects are challenging? _____

Are there any special needs: ☐ Yes ☐ No **If yes, diagnosis and treatment:** _____

Educator Signature: _____ Date: _____

To refer this patient: ☐ Fax a copy of this form

Our staff will contact the patient within 1-2 business days. A copy of the report and exam findings will be sent to the referring provider. We do not do general/primary eye care.