VISION
DEVELOPMENT
CENTER

VISION THERAPY REFERRAL

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Referring Provider: ______________________________

Name: ______________________________ DOB: ______________

Phone: ______________________ Email: ______________________

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

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

☐ Diplopia
☐ Blurred Vision
☐ Eye Fatigue/Strain
☐ Headaches
☐ Poor Eye Tracking
☐ Poor Depth Perception
☐ Decreased Attention/Concentration
☐ Poor Reading Speed/Fluency/Accuracy
☐ Concussion/Brain Injury
☐ Amblyopia (Lazy Eye)
☐ Strabismus (Wandering Eye)
☐ Other: ______________________________

Diagnosis if known: ______________________________

Additional information if known: ______________________________

Are there any ocular health disorders: Yes or No **If yes, diagnosis and treatment:** ______________

Manifest Rx: ______________________
OD: ______________________
OS: ______________________
Add: ______________________

Were glasses prescribed? Yes or No
Contact lenses if prescribed:
OD: ______________________
OS: ______________________

Provider Signature: ______________________________ Date: ______________

To refer this patient: ☐ Fax a copy of this form ☐ Fax most recent eye exam

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 doctor. We do not do general/primary eye care. All patients will return to referring doctor's office for all general/primary eye care and glasses needs.