VISION
DEVELOPMENT
CENTER

VISION THERAPY REFERRAL

Dr. Allison Toler, OD, FAAO, FCOVD
352.243.4673 | Fax 352.260.0884 | www.Hope.Vision
235 Citrus Tower Blvd., Suite 107, Clermont, FL 34711

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)

- ☐ 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: _____

Diagnosis if known: _____

Additional information if known: _____

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

Provider 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.