Academy of Vision and Learning, Optometry
Qiaoqiao Wang O.D., Ph.D

Optometric Vision Therapy Referral and Consultation Form

Patient Name: _____ Date of Birth _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Referring Doctor:_____

Address, City, State, Zip: _____

Phone #:_____Fax #: _____

Email:_____

I am referring the patient listed above to your office for the following reason(s):

- ☐ Eye Strain/Headaches
- ☐ Reading/TV/ Computer Use
- ☐ Strabismus/Amblyopia
- ☐ Fluctuating Acuity
- ☐ Developmental Delays
- ☐ Double Vision
- ☐ Sports Vision Evaluation
- ☐ Infant/Preschool Evaluation
- ☐ Accommodative Dysfunction
- ☐ Exophoria/Esophoria/Hyperphoria
- ☐ Perceptual Evaluation
- ☐ Poor School Performance
- ☐ Other:

Eyeglasses Prescription :

OD:_____

OS:_____

Additional Information: _____

Please attach the most recent medical record of comprehensive eye exam. Thank you for kind referral.

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