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

Behavioral Optometric Care Referral and Consultation Form

Patient Name: _____ Date of Birth_____

Patient Phone Number: _____

Patient's Email address (if any) _____

Referring Doctor Name: _____

Office Phone #: _____Office 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:

Additional Information:

_____

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

2514 Boston Post Road, Guilford, CT 06437 Phone 203-453-4813 Fax 203-738-0523
http://www.avlseebright.com Email: dr.wang@avlseebright.com