Academy of Vision and Learning

Integrated Vision Care

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Optometric Vision Therapy 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:

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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