Vision Therapy Referral Form

From the office of (please include clinic name and phone number below):

Type of developmental vision care requested:

- ❒ Consult and render opinion only.
- ❒ Evaluation and subsequent care if needed.
- ❒ Other:_____

Patient Name: _____ DOB: _____

Diagnosis: _____ Code (optional): _____

Parent/Guardian Name: _____

Patient's Address:_____

City: _____ State: _____ Zip: _____

Phone (day): _____

Today's date_____ Referring Professional: _____

Check all conditions that apply or are in question:

□ Blurred vision
□ Asthenopia/visual fatigue
□ Diplopia
□ Strabismus
□ Reduced acuity/amblyopia
□ Convergence insufficiency
□ Unsure of responses/Streff Syndrome
□ Other:

□ Lower 1/3 of class
□ Reading/learning problems
□ "Just not doing as well as he/she should"
□ "Good student who wants to do better work"
□ Good student who takes too long to complete homework
□ Special needs (Autism, C.P., AD(H)D, deaf, low vision)
□ Infant/toddler
□ Toddler/preschool delayed development

□ Yes □ No Visual Fields have been completed on the patient
□ Yes □ No Dilated Fundus exam was within normal limits

Pertinent Diagnostic Findings and Comments:

_____

_____

_____ _____
Tech/Staff (signature) Doctor (signature)

Please call Dr. Metzger's office at 913-469-8686 to schedule this patient for a developmental vision evaluation. Please leave a message, if necessary. **Also, FAX this REFERRAL FORM and the patient's current VISION RECORDS to 913-469-8688.**

Thank you for allowing Dr. Metzger to share in your patient's vision care. A report will be sent to your office at the completion of services.