



Type of vision care requested:

- Consult and render opinion only
- Neuro-optometry evaluation and treatment
- On-site workplace visual task evaluation
- Other: _____

Patient Name: _____ **DOB:** _____

Diagnosis: _____ **Code (optional):** _____

Spouse/Care giver Name: _____

Patient's Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Referring Professional: _____

Referring Office: _____

Contact Phone: _____

Check all conditions that apply or are in question:

- | | |
|--|---|
| <input type="checkbox"/> Decreased distance acuity | <input type="checkbox"/> Difficulty moving/turning eyes |
| <input type="checkbox"/> Difficulty with reading | <input type="checkbox"/> Wandering eyes |
| <input type="checkbox"/> Known V.F. loss or restrictions | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Permanent loss of acuity at any level | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Photophobia or glare problems | <input type="checkbox"/> Visual neglect |
| <input type="checkbox"/> Diplopia or ghost images | <input type="checkbox"/> Balance/gait aberrations, or dizziness |
| <input type="checkbox"/> Unusual body-neck-head posture | <input type="checkbox"/> Unresolved visual complaints |
| <input type="checkbox"/> Objects "jump" into or out of field of vision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Post stroke, TBI, concussion | |

Additional information:

Doctor (signature)

Date

Please fax this form, the patient's contact information, and current vision records to (913) 469-8688.

We will contact the patient to schedule and prepare them to visit our office. If you have questions, please call (913) 469-8686.

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