kc vision performance
an alphapointe program

Vision Therapy Referral Form

Type of 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: _____

Referring Professional: _____

Referring Office: _____

Contact Phone: _____

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
- ☐ Infant/toddler
- ☐ Toddler/preschool delayed development

Pertinent diagnostic information and comments:

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

_____

_____

_____ _____

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.