Referral for Vision Services

Alphapointe and KC Vision Performance
Phone: (816) 237-2020
Fax: (816) 237-2065

Patient name: ___________________________________DOB:_________

Telephone: (_____) _______________________

Reason for Referral:

- o Low Vision Evaluation/Services
- o Occupational Therapy Evaluation/Services
- o Neuro-Optometry Evaluation/Services
- o Vision Therapy Evaluation/Services

Functional difficulties due to vision (check all that apply):

□ Reading, writing, homework

□ ADL's (activities of daily living)

□ Getting/Keeping a job

□ Moving around safely (falling)

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□ Driving

□ Other ____

***<u>Please fax the following with referral:</u> Copy of Last office visit note, including visual fields (if available), demographics and insurance information.**

Referring Doctor/Person: _____________________________________

Referring Agency: ____

Telephone: (___)__________________FAX: (__)__________________