Visual Therapy Assessment Referral

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PATIENT NAME: Mr / Mst / Mrs / Miss / Ms

DOB: AHC#:

PHONE #: ADDRESS:

Email:

REASON FOR REFERRAL:

□ Learning Difficulty □ Visual Perceptual Testing □ Amblyopia □ Strabismus
□ Convergence Insufficiency □ Binocular Coordination/Accommodative dysfunction
□ Other:_____

Comments/History:

Any previous eye surgeries? Yes / No _____

Medications: Refraction: OD VA 20/

OS VA 20/

Were glasses prescribed? Yes / No Are glasses currently being used by the patient? Yes / No

Ocular Health: EOM's: Any EOM restrictions/palsy/paresis? Yes / No

Binocular Vision Test results:

Accommodation Test results:

Any previous visual training or treatment (ie. patching etc)?

Referring Optometrist: _____

Referring office fax #: _____

Referring email address: _____