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FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION REFERRAL FORM

Referring Provider Office

Clinic: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Code (optional): _____

Parent/Guardian Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone (preferred): _____

Today's date: _____ Referring Professional: _____

Reason(s) for Referral:

- ☐ Reading/School Problems
- ☐ Strabismus/Amblyopia
- ☐ Convergence Insufficiency
- ☐ Visual Discomfort/Headaches
- ☐ Attention Problems
- ☐ Convergence Excess
- ☐ Post Trauma/Stroke Evaluation
- ☐ Accommodative Dysfunction
- ☐ Other:

Results of Examination
(If you do not have the equipment to perform the tests, please let us know)

Refraction: OD_____ VA OD_____ SRx OD_____

OS_____ VA OS_____ SRx OS_____
(if given)

☐ DFE performed – no ocular health abnormalities noted Other: _____

Fixation: _____ Distance Cover test: _____ Near cover test: _____

Accommodative facilities: _____ Dynamic Vision: _____ NPC: _____ MEM: _____

NRA: _____ PRA: _____ Vergence Ranges (BI/BO): Distance: _____ Near: _____ Stereopsis: _____

I hereby grant permission for Dr. Michelle Cohen and any other practitioner involved in my care to exchange information concerning patient case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Dr. Cohen so that her office can contact me (or an appointed representative) to schedule an evaluation.

_____

Patient/Parent (Guardian) Signature Date Doctor Signature

A copy of all test results and a report will be sent to the referring provider.