REFERRAL FORM

Patient name:________________________________ DOB:___________________

Parent name (if applicable):____

Address:____

Phone number:____

Reason for referral:

- o Strabismus (“eye turn”)
- o Amblyopia (“lazy eye”)
- o Binocular Vision Evaluation
- o Learning Problems
- o Brain Injury Evaluation
- o Other (please specify):____________________________________

Pertinent Clinical Findings:____

To assist in caring for your patients please include current clinical notes or patient records. This allows us to avoid repeating services.

Did you perform a comprehensive eye examination?

- o Yes
  - o Date:____________________
  - o Dilation performed
  - o Records attached
- o No

May we contact the patient for an appointment?

- o Yes
- o No

Referring physician/provider:____

Phone number:_____________________________ Fax:_________________________

Please send this completed form with any pertinent records to:
Fax: 307-237-1370 Email: visiontherapycvc@gmail.com
Thank you for your referral, we look forward to working with you!