

# VISION THERAPY REFERRAL FORM

From the office of (Please include name and contact information):

---

**Type of developmental 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 (day): \_\_\_\_\_

Today's date \_\_\_\_\_ Referring Professional: \_\_\_\_\_

**Check all conditions that apply or are in question:**

- |  |   |
|--|---|
| <input type="checkbox"/> Blurred vision                      | <input type="checkbox"/> Lower 1/3 of class                                     |
| <input type="checkbox"/> Asthenopia/visual fatigue           | <input type="checkbox"/> Reading/learning problems                              |
| <input type="checkbox"/> Diplopia                            | <input type="checkbox"/> "Just not doing as well as he/she should"              |
| <input type="checkbox"/> Strabismus                          | <input type="checkbox"/> "Good student who wants to do better work"             |
| <input type="checkbox"/> Reduced acuity/amblyopia            | <input type="checkbox"/> Good student who takes too long to complete homework   |
| <input type="checkbox"/> Convergence insufficiency           | <input type="checkbox"/> Special needs (Autism, C.P., AD(H)D, deaf, low vision) |
| <input type="checkbox"/> Unsure of responses/Streff Syndrome | <input type="checkbox"/> Infant/toddler   |
| <input type="checkbox"/> Other:                              | <input type="checkbox"/> Toddler/preschool delayed development                  |

Yes  No Visual Fields have been completed on the patient

Yes  No Dilated Fundus exam was within normal limits

Pertinent Diagnostic Findings and Comments:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Tech/Staff (signature)

\_\_\_\_\_  
Doctor (signature)

**To schedule this patient for a developmental vision evaluation, please fax this REFERRAL FORM and the patient's current vision records to Dr. John Metzger, Vision Therapy KC at 913-469-8688.**

We appreciate your time and effort to refer your patient for our services. You will receive a report from Dr. Metzger after seeing your patient.