foundation for VISION THERAPY Awareness

Referral for Vision Therapy Services

(Please include the patient's chart notes and demographic information)

Referring Provider: _____

Clinic: _____

Patient Information

Name: _____

DOB: _____ Phone: _____

Parent/Guardian: _____

Pertinent Visual Signs/Symptoms/Exam Findings/Reason for Referral:
(check all that apply)

- ❑ Diplopia
- ❑ Blurred Vision
- ❑ Eye Fatigue/Strain
- ❑ Headaches
- ❑ Poor Eye Tracking
- ❑ Poor Depth Perception
- ❑ Other:
- ❑ Poor Reading Speed/Fluency/Accuracy
- ❑ Decreased Attention/Concentration
- ❑ Concussion/Brain Injury
- ❑ Dizziness/Vertigo
- ❑ Amblyopia (Lazy Eye)
- ❑ Strabismus (Wandering Eye)

Provider Signature: _____ Date: _____