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A digital copy of this form can be found at www.InlandVT.com

VISION THERAPY REFERRAL & CONSULTATION FORM

PATIENT INFORMATION

Name:____ DOB:____________________ Age:__________ M / F

Phone:____________________________ Medical Insurance:____

Parent/Guardian Name (if applicable):____

REASON FOR REFERRAL (PLEASE CHECK ALL THAT APPLY)

- ❑ Poor Eye Tracking
- ❑ Poor Accommodation
- ❑ Poor Con/Div-vergence
- ❑ Poor Coordination
- ❑ Poor Depth Perception
- ❑ High CISS Score: ________
- ❑ Diplopia
- ❑ Blurred vision
- ❑ Headaches
- ❑ Eye strain / fatigue / pain
- ❑ Suppression
- ❑ Other: ____
- ❑ Dizziness / Vertigo
- ❑ Learning Related Problems
- ❑ Strabismus
- ❑ Amblyopia
- ❑ Concussion / Brain Injury

Diagnosis (if known):____

IMPORTANT DETAILS FROM EYE EXAM

***** PLEASE ATTACH CHART NOTES OF MOST RECENT COMPREHENSIVE EYE EXAM *****

☐Yes ☐No Any ocular health concerns? Describe:____

☐Yes ☐No Were glasses or contacts prescribed?

Manifest Refraction:		Final Rx (if different than MR):		Contact Lens Rx:
OD:______________________	20/____	OD: ____________________	Add:	OD: __________________________
OS:______________________	20/____	OS: ____________________	+_______	OS: __________________________

Additional Information:____

REFERRING PROVIDER CONTACT INFORMATION

Name:___________________________ ❑OD ❑MD/DO ❑DC ❑OT ❑PT ❑Other:________________

Clinic Name:___________________________________ Email:____

Clinic Fax #:___________________________________ Phone #:______________________________________

Provider Signature: ____ **Date:**________________________

THANK YOU!
TRANSFORMING LIVES WITH TRUE VISION