INLAND VISION THERAPY

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Vision Therapy Referral & Consultation Form

Patient Information

Name:_____ DOB:_____ Age:_____

Phone:_____ Parent/Guardian Name (if applicable):_____

Medical Insurance:_____

Reason for Referral (please check all that apply)

- ❑ Poor Eye Tracking
- ❑ Poor Accommodation
- ❑ Poor Con/Div-vergence
- ❑ Poor Coordination
- ❑ Poor Depth Perception
- ❑ Diplopia
- ❑ Blurred vision
- ❑ Headaches
- ❑ Eye strain / fatigue / pain
- ❑ Dizziness / Vertigo
- ❑ Learning Related Problems
- ❑ Strabismus
- ❑ Amblyopia
- ❑ Concussion / Brain Injury

Other:_____

Diagnosis (if known):_____

Important Details from Eye Exam

- Any ocular health concerns? □Yes □No If Yes, Diagnosis & Plan:_____
- Were Glasses Prescribed? □Yes □No Were Contact Lenses Prescribed? □Yes □No

Manifest Rx:
OD:_____VA: 20/_____
OS:_____ VA: 20/_____

Contact Lens Rx:
OD:_____
OS:_____

Additional Information:_____

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

Referring Doctor/Professional Information

Name:_____ ❑OD ❑MD/DO ❑DC ❑OT ❑PT ❑Other:_____

Clinic Name:_____

Phone:_____ Email:_____

Provider Signature: _____ Date:_____

TRANSFORMING LIVES WITH TRUE VISION