Vision Learning Center
Amanda Judson, OD, MS, FCOVD

REFERRAL FORM FOR VISION THERAPY CONSULTATION

Patient Name ____

Date of Birth______________________**Age**__________**Sex**: M ☐ F ☐ **Grade** ______________________________

Address____

Reason for Referral/Specific Questions to be answered: ____

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Referring Professional: ____

A representative of our office will contact the patient or patient's parents/guardians to set up an evaluation.

Parent's/Guardian's Name: ____

Relationship to Patient: ______________________________

Best Contact Phone Number: ____________________________________

Best Contact Time to contact Patient/Parent/Guardian: ______________________________

Insurance Type _______Private Major Medical _______Hoosier Health/Medicaid _______Uninsured

Referring office, please fax this form to 812-232-1007

Appt Scheduled: ___ Yes ___ No Date Scheduled: ________________________________