Vision Learning Center
Amanda Judson, OD, MS, FCOVD

OPTOMETRIST 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: _____

_____

_____

_____

Exam Findings (Date of Exam:_____)

Quality of Life Score (please include QOL Form): _____

Hab Rx OD _____OS _____

Purpose _____

New Rx OD _____OS _____

Purpose _____

Are you holding New Rx until seen by Dr. Judson? ☐ Yes ☐ **No** ☐ N/A

cc sc VA D OD 20/_____ OS 20/_____ OU 20/_____

N OD 20/_____ OS 20/_____ OU 20/_____

NPA (near point of accommodation) OD _____ OS _____ OU _____

NPC (near point of convergence) _____

cc sc CT D _____N _____

Stereo _____ Method _____

Referring Optometrist: _____

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: _____