VISION THERAPY CENTER

Dr. John Jacobi, OD, FCOVD
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FAX REFERRAL FORM

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Parent/Guardian/Hospital/Agency

Address

City State Zip

Area Code Phone Best time to call

Pertinent Symptoms/ History: _____

Reason(s) for Referral:

- ☐ School Difficulty
- ☐ Strabismus/Amblyopia
- ☐ Asthenopia
- ☐ Visual Discomfort/Headaches
- ☐ Convergence/Divergence
- ☐ Other: _____
- ☐ Post Trauma/Stroke Evaluation
- ☐ Problems seeing 3D

Results of Examination

Eyeglass Rx OD _____ VA OD _____
OS _____ VA OS _____

Binocular Status: _____ Eye Health: _____

Other Pertinent Results of Examination: _____

I hereby grant permission for Suburban Eye Care, P.C. and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Suburban Eye Care, P.C. so that their office can contact me (or an appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor)

A copy of all tests results and a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary care and eyeglass prescriptions.