☐ Colorado Springs Office
1710 Jet Stream Dr, Ste 100
Colorado Springs, CO 80921
Phone: 719-302-8922

☐ Castle Pines Office
363 Village Square Ln, Ste 155
Castle Pines, CO 80108
Phone: 720-726-5128

Please Fax Exam Notes and Demographic To: (866) 477-3130

Joshua Watt, OD, FCOVD *Developmental Optometrist*

FAX REFERRAL FORM

_____ Date

_____ Referred By

_____ Address

_____ City State

_____ Area Code Phone

_____ Patient's Name DOB

_____ Contact Information: Parent's Name

_____ Address

_____

_____ Area Code Phone Best time to call

Reason(s) for Referral:

☐ School Problems/Dyslexia
☐ Strabismus/Amblyopia
☐ Convergence Insufficiency
☐ Visual Discomfort/Headaches
☐ Attention problems/ADHD
☐ Convergence Excess
☐ Post Trauma/Stroke Evaluation
☐ Tracking/Oculomotor Dysfunction
☐ Other:_____

Results of Examination

Refraction: OD_____ VA OD_____ SRx OD_____

OS_____ VA OS_____ SRx OS_____

(if given)

☐ DFE performed – no ocular health abnormalities noted Other: _____

Additional information: _____

_____

_____

I hereby grant permission for Dr. Joshua Watt and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc.

I also hereby give permission to have this information faxed to Dr. Watt so that his office can contact me (or my 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 eye care and eyeglass prescriptions.