



Colorado Springs Office
 1710 Jet Stream Dr, Ste 215
 Colorado Springs, CO 80921
 Phone: 719-302-8922

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 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, O.D., F.C.O.V.D. 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> School Problems/Dyslexia | <input type="checkbox"/> Visual Discomfort/Headaches | <input type="checkbox"/> Post Trauma/Stroke Evaluation |
| <input type="checkbox"/> Strabismus/Amblyopia | <input type="checkbox"/> Attention problems/ADHD | <input type="checkbox"/> Tracking/Oculomotor Dysfunction |
| <input type="checkbox"/> Convergence Insufficiency | <input type="checkbox"/> Convergence Excess | <input type="checkbox"/> 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.*