Focus Vision
THERAPY CENTER

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BINOCULAR VISION EVALUATION
FAX REFERRAL FORM

Date ______________________

Referred By ______________________

Address ______________________

City ______ State ______ Zip ______

Area Code ______ Phone ______

Patient's Name ______ DOB ______

Contact Information: Parent's Name ______

Address ______________________

City ______ State ______ Zip ______

Area Code ______ Phone ______ Best time to call ______

Reason(s) for Referral:

- ❑ Visual Discomfort/Headaches
- ❑ Strabismus/Eye Turn
- ❑ Avoids Reading/Difficulty with Near Work
- ❑ Eye-Hand Coordination Problems
- ❑ Visual Motor Dysfunction
- ❑ Other:________________
- ❑ Post-Concussion Vision Evaluation
- ❑ Amblyopia/Lazy Eye
- ❑ Tracking Problems
- ❑ Vestibular problems
- ❑ Evaluate for vision problems associated with special needs

Pertinent Symptoms/ History:

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I hereby grant permission for Focus Vision Therapy 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 Focus Vision Therapy so that their office can contact me (or my appointed representative) to schedule an evaluation.

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www.focusidaho.com

Fax: (208) 939-0522

Patient/Parent Signature Date