**Scott R. Lewis, O.D., FCOVD**
*Developmental Optometrists*

# FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION FAX REFERRAL FORM

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Parent's Name

Address

City State Zip

Area Code Phone Best time to call

**Reason(s) for Referral:**

School Problems/Dyslexia
Strabismus/Amblyopia
Convergence Insufficiency
Visual Discomfort/Headaches
AD(H)D
Convergence Excess
Post Trauma/Stroke Evaluation
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. Scott Lewis 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. Lewis so that his office can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor)

***A report of testing and findings will be sent to the referring doctor.***
***Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.***

3268 W. Bavaria St. Eagle, ID 83616 –Phone (208) 939-0510–Fax (208) 939-0522 – www.focusidaho.com