Vision Therapy Referral Form

Patient Information:

Patient Name: ____

Patient DOB: ____

Patient Phone Number: ____

Patient Email Address: ____

Referring Physician Information:

Name: ____

Name of Practice: ____

Email: ____

☐ Please check here if you would like a patient report to be sent to your office.

Reason for Referral:

____

____

____

☐ Amblyopia Evaluation

☐ Visual Skills Evaluation

☐ Visual Perceptual Evaluation

Please fax referral form to West Palm Beach office at: **(561) 964-8771**

Premier Eye Center Plantation
7045 W. Broward Blvd.
Plantation, FL 33317
P: (954)625-2388
F:(954)625-2390

Premier Eye Center Boca Raton
7840 Glades Rd. Suite 245
Boca Raton, FL 33434
P:(561)482-8300
F:(561)482-8381

Premier Eye Center West Palm Beach
3650 Forest Hill Blvd. Suite 2
West Palm Beach, FL 33406
P:(561)264-1359
F:(561)964-8771