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FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION REFERRAL FORM

Date _____ Referred By _____ Patient's Name _____ DOB _____

Address _____ Contact Information: Parent/Guardian/Hospital/Agency

City _____ State _____ Zip _____ Address _____

Phone _____ City _____ State _____ Zip _____

E-mail Address _____ ( ) Phone Number _____ Best time to call _____

Fax _____ Appointment date and time (if scheduled) _____

Pertinent Symptoms/History: _____

Eyeglass Rx OD _____ Add _____ DVA OD _____ NVA OD _____

OS _____ Add _____ DVA OS _____ NVA OS _____

Distance Phoria _____ Near Phoria _____ Vergence Skills: _____

NRA _____ PRA _____ NPC _____ Other functional test results: _____

Other Pertinent Results of Examination: _____

Have Visual Fields been performed? _____ Results: _____

Has a cycloplegic or dilated fundus exam been performed? _____ Results: _____

Check all conditions that apply or are in need of consult:

- ☐ accommodative anomaly
- ☐ amblyopia
- ☐ asthenopia
- ☐ blurred vision
- ☐ convergence insufficiency
- ☐ diplopia
- ☐ divergence anomaly
- ☐ head trauma
- ☐ learning problems
- ☐ nonverbal patient
- ☐ ocular pathology
- ☐ oculomotor dysfunction
- ☐ reading problems
- ☐ reduced binocular vision
- ☐ special needs patient
- ☐ sports vision training
- ☐ Strabismus
- ☐ unknown cause of reduced visual acuity
- ☐ very young child
- ☐ headaches
- ☐ other

Comments: _____

I hereby grant permission for Dr._____ and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby, give permission to have this information faxed to Dr. Simonson so their appointed representative can contact me to schedule an evaluation.

Patient/Parent Signature _____ Date _____ Signature (Doctor) _____ Date _____

A report will be sent to the referring doctor.
Patient will return to referring doctor's office for all primary care, medical care, contact lens fittings and eyeglass prescriptions.