CHARRON
VISION THERAPY

Visual Evaluation Referral Form

Referring Provider:_____ Facility Phone:_____

Facility Name:_____

Patient Full Name:_____ Date of Birth:_____

Guardian Full Name:_____ Best Phone:_____

Patient Address:_____

_____

Diagnosis/Reason(s) For Referral

□ Visual Perceptual Problems	□ Visual Discomfort/Headaches	□ TBI/Stroke Evaluation
□ Difficulty with Close Work	□ Amblyopia/"Lazy Eye"	□ Concussion
□ Letter Reversals	□ Developmental Delays	□ Attention - ADD/ADHD
□ Autism Spectrum Disorder	□ Tracking Problems	□ Head Movement while Reading
□ Learning Problem	□ Eye-Hand Coordination Problems	□ Vestibular Problems
□ Strabismus/Eye Turn	□ Visual Motor Dysfunction	□ Other:_____

Pertinent Symptoms/History:_____

_____

_____

_____

_____

A copy of all tests results and/or a report will be sent to the referring doctor.

Patients will return to referring doctor e and eyeglass prescriptions

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