Zenith Vision Development Center

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BINOCULAR VISION EVALUATION

PLEASE FAX TO (218) 461-4885

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Date

____
Referred By

____
Address

____
City State Zip Code

____
Area Code Phone

____
Email Address

____
Patient's Name Date of Birth

____
Contact Information: Parent's Name

____
Address

____
City State Zip Code

____
Area Code Phone Best time to call

____
Email Address

Reason(s) for Referral:

- ☐ Convergence Insufficiency/Excess
- ☐ Tracking/Oculomotor Concerns
- ☐ Accommodative Disorder
- ☐ Diplopia
- ☐ Divergence Insufficiency/Excess
- ☐ Strabismus/Amblyopia
- ☐ Difficulty Reading/Learning
- ☐ Post Trauma/Stroke Vision Evaluation
- ☐ Visual Discomfort/Headaches
- ☐ 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/pertinent findings:

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A report will be sent to the referring doctor.
Patient will return to referring doctor's office for all primary eye care and eyeglass prescriptions.