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BINOCULAR VISION EVALUATION

PLEASE FAX TO (218) 461-4885

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:

- ☐ Amblyopia/Lazy Eye
- ☐ Strabismus/Eye Turn
- ☐ Headaches with close work
- ☐ Difficulty with close work
- ☐ Convergence Insufficiency
- ☐ Developmental Delay
- ☐ Other:_____
- ☐ Eye-Hand Coordination Problems
- ☐ Attention Problems, ADD/ADHD
- ☐ Learning Problem
- ☐ Letter Reversals
- ☐ Tracking Problems
- ☐ Motion Sickness/Vertigo/Dizziness
- ☐ Post-Concussion Vision Evaluation
- ☐ Head Movement while Reading
- ☐ Visual Discomfort/Headaches
- ☐ Visual Motor Dysfunction
- ☐ Balance/Movement Difficulty
- ☐ Nystagmus

Pertinent symptoms or history: _____

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Additional information or concerns: _____

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