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# VISION EVALUATION REFERRAL FORM

**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:**

- ☐ Failed Vision Screening
- ☐ Difficulty with/Avoids Reading
- ☐ Tracking Problems
- ☐ Visual Motor Dysfunction
- ☐ Developmental Delay
- ☐ Other:_____
- ☐ InfantSEE Examination
- ☐ Amblyopia/Lazy Eye
- ☐ Eye-Hand Coordination Problems
- ☐ Letter Reversals
- ☐ Motion Sickness/Vertigo/Dizziness
- ☐ Failed Convergence Screening*
- ☐ Strabismus/Eye Turn
- ☐ Post-Concussion Vision Evaluation
- ☐ Visual Discomfort/Headaches
- ☐ Nystagmus

**Pertinent symptoms or history:** _____

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***Additional information or concerns:*** _____

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*For more information regarding the Convergence Screening, please check here: ☐