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VISION THERAPY AND CONSULTATION 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:

- ☐ Visual Discomfort/Headaches
- ☐ Tracking/Oculomotor Concerns
- ☐ Accommodative Disorder
- ☐ Double Vision
- ☐ Post-Trauma/Head Injury
- ☐ Strabismus/Amblyopia
- ☐ Difficulty Reading/Learning
- ☐ Gross Motor/Coordination
- ☐ Perceptual Issues
- ☐ Other:_____

Additional Information

Has the patient had a comprehensive eye examination within the last 6 months? ☐ **Yes** ☐ **No/Unknown**

A copy of the report and exam findings will be available upon request.