OPTOMETRIC VISION THERAPY REFERRAL FORM

PHONE: (770) 904-0979

Please fax this referral form to the preferred location.
PVDC will personally contact your patient to discuss our services:

□ **Cumming location**	□ **Dacula location**
Fax: (470) 297-3854	Fax: (470) 655-7914

Date_____ Patient Name_____ M / F DOB_____

Parent/Guardian Name_____ Contact number: _____

Eye Examination History:

Last eye exam:___/___/___ Ocular Health: ☐ Unremarkable OD and OS. ☐Other:_____

Glasses/CL Rx & BVAs: ☐ No Rx ☐ Rx:_____

Reason for referral for a Pediatric Evaluation:

☐ Special Needs Evaluation
☐ Evaluation for ≤ 6yo
☐ InfantSEE Evaluation
☐ Other_____

Reason for referral for a Vision Therapy Evaluation/Treatment:

☐ Visual Perceptual deficits/ Difficulties in school
☐ Hyper/Hypo Tropia
☐ Accommodative Dysfunction
☐ Eso/Exo Phoria (EP/ XP)
☐ Amblyopia
☐ Convergence Insufficiency
☐ Binocular Vision Dysfunction
☐ Convergence Excess
☐ Esotropia (ET)
☐ Ocular Motor Dysfunction
☐ Exotropia (XT)
☐ Concussion/ Neuro-Visual Rehabilitation
☐ Sports Vision Training
☐ Other_____

Notes: _____

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REFERRING PERSON: _____

REFERRING LOCATION: _____