



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

Fax: (470) 297-3854

Dacula location

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 \leq 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: _____

REFERRING PERSON: _____

REFERRING LOCATION: _____

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT YOU ARE HERBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, NOTIFY US IMMEDIATELY. PLEASE ADVISE US OF ANY DIFFICULTIES IN RECEIVING THIS TRANSMISSION BY CALLING THE NUMBER LISTED ABOVE.