OPTOMETRIC EVALUATION 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: _____

Reason for referral for a Pediatric Evaluation:

☐ Special Needs Evaluation
☐ InfantSEE Evaluation
☐ Other_____
☐ Failed Vision Screening/Poor Acuity
☐ Back To School Evaluation

Reason for referral for a Vision Therapy Evaluation/Treatment:

☐ Visual Perceptual deficits/ Difficulties in school
☐ Strabismus/Eye turn
☐ Amblyopia/Lazy Eye
☐ Sports Vision Training
☐ Convergence Insufficiency
☐ Ocular Motor Dysfunction
☐ Concussion/ Neuro-Visual Rehabilitation
☐ Other_____

Notes: _____

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REFERRING PERSON: _____

REFERRING LOCATION: _____