



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
Fax: (470) 297-3854

Dacula location
Fax: (470) 655-7914

Date _____ Patient Name _____ M / F DOB _____

Parent/Guardian Name _____ Contact number: _____

Reason for referral for a Pediatric Evaluation:

- | | |
|---|--|
| <input type="checkbox"/> Special Needs Evaluation | <input type="checkbox"/> Failed Vision Screening/Poor Acuity |
| <input type="checkbox"/> InfantSEE Evaluation | <input type="checkbox"/> Back To School Evaluation |
| <input type="checkbox"/> Other _____ | |

Reason for referral for a Vision Therapy Evaluation/Treatment:

- | | |
|---|--|
| <input type="checkbox"/> Visual Perceptual deficits/ Difficulties in school | <input type="checkbox"/> Convergence Insufficiency |
| <input type="checkbox"/> Strabismus/Eye turn | <input type="checkbox"/> Ocular Motor Dysfunction |
| <input type="checkbox"/> Amblyopia/Lazy Eye | <input type="checkbox"/> Concussion/ Neuro-Visual Rehabilitation |
| <input type="checkbox"/> Sports Vision Training | <input type="checkbox"/> Other _____ |

Notes: _____

REFERRING PERSON: _____

REFERRING LOCATION: _____

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