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Referral Form

From the office of (please include clinic name and phone number below):

Clinic: _____ Phone: _____ Fax: _____

Type of developmental vision care requested:

☐ Consult and render opinion only.

☐ Evaluation and subsequent care if needed.

☐ Other: _____

Patient Name: _____ DOB: _____

Patient Insurance: Name:_____ ID#_____ Group#_____

Diagnosis: _____ Code (optional): _____

Parent/Guardian Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone (day): _____

Today's date_____ Referring Professional: _____

Reason(s) for Referral:

- ❑ Strabismus/Eye Turn
- ❑ Amblyopia/Lazy Eye
- ❑ Visual Perceptual Problems
- ❑ Visual Motor Dysfunction
- ❑ Other:_____
- ❑ Developmental Delay
- ❑ Attention Problems, ADD/ADHD
- ❑ Eye-Hand Coordination Problems
- ❑ Tracking Problems
- ❑ Post Trauma/Stroke Evaluation
- ❑ Autism Spectrum Disorder
- ❑ Head Movement while Reading
- ❑ Avoidance/Difficulty with Close Work

I hereby grant permission for Dr. Michelle Cohen and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Dr. Cohen so that her office can contact me (or an appointed representative) to schedule an evaluation.

_____

Patient/Parent (Guardian) Signature Date Signature (MD, PhD, OT, PT, etc.)

A copy of all tests results and a report will be sent to the referrer.