SEATTLE VISION THERAPY & REHABILITATION CENTER

BINOCULAR/LOW VISION EVALUATION
FAX REFERRAL FORM
PLEASE FAX WITH A COPY OF MOST RECENT EXAM TO:
(206) 536-3249

Date

Referred By

Address

City State Zip Code

Area Code Phone

Patient's Name Date of Birth

Contact Information: Parent's Name

Address

City State Zip Code

Area Code Phone Best time to call

Email Address

Reason(s) for Referral:

- ☐ Reading/School Problems
- ☐ Strabismus/Amblyopia
- ☐ Convergence Insufficiency
- ☐ Divergence Excess
- ☐ Visual Discomfort/Headaches
- ☐ Attention Problems
- ☐ Convergence Excess
- ☐ Low Vision Evaluation
- ☐ Post Trauma/Stroke Vision Evaluation
- ☐ Sensory Processing Disorders
- ☐ Developmental Delays & Special Needs
- ☐ Other:_____

Results of Examination

Refraction:OD_____ VA OD 20/____ SRx OD_____

OS_____ VA OS 20/____ SRx OS_____

(if given)

☐ DFE performed – no ocular health abnormalities noted Other: _____

Additional information/pertinent findings:

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A report will be sent to the referring doctor.
Patient will return to referring doctor's office for all primary eye care and eyeglass prescriptions.
Electronic copy available at seattlevisioncenter.com