Wichita Optometry P.A.

12111 W. Maple Street #125 - Wichita **415 SE Louis Drive - Mulvane**

Binocular VT Referral Form

Phone#: (316)942-7496 Fax#: (316) 239-2557

Date:_____

Referring Doctor:_____
Name of Patient:_____ **DOB:**_____
Responsible Party Name:_____
Relationship to Patient:_____
Address:_____**City:**_____**Zip:**_____
Phone #:_____**Insurance:**_____

Diagnosis: (Check all that apply)

☐ Accommodative Deficiency
☐ Amblyopia
☐ Convergence Excess
☐ Convergence Insufficiency
☐ Esotropia or Exotropia
☐ Oculomotor Dysfunction
☐ Perceptual Problems
☐ Other _____

Current RX

OD:_____OS:_____

Background and History

Acuity: OD:_____OS:_____

Appointment Date:_____**Time:**_____

Doctor's Signature:_____

Thank you for your referral. We will send you copies of all progress exams and refer back any eyewear that might be needed. If you have any questions, please give our office a call.