Binocular VT Referral Form

12111 W. Maple Street #125 - Wichita
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.