BINOCULAR VISION EVALUATION FAX REFERRAL FORM
Fax to: 408.739.2439

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Parent's Name

Address

City State Zip

Area Code Phone Best time to call

Email Address

Reason(s) for Referral:

- ☐ Vergence Disorder
- ☐ Strabismus/Amblyopia
- ☐ Visual Discomfort/Headaches
- ☐ Accommodative Disorder
- ☐ Tracking Dysfunction
- ☐ Reading/School Problems
- ☐ Post Trauma/Stroke Evaluation
- ☐ Special Needs
- ☐ Other:_____

Results of Examination

Refraction: OD_____ VA OD_____ SRx OD_____

OS_____ VA OS_____ SRx OS_____

(if given)

- ☐ DFE performed – no ocular health abnormalities noted Other: _____
- ☐ Eye Exam/Chart FAXed

Additional information: _____

I hereby grant permission for Vision Enhancement Optometric Group and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc.

I also hereby give permission to have this information faxed to Vision Enhancement Optometric Group so that their office can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature Date

Doctor Signature Date

A copy of all tests results and a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.
Please provide a copy of this form to the patient to bring into their consultation.

□ Please check if new supply of fax forms are needed

Vision Enhancement Optometric Group
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