Optometric Vision Therapy Referral Form

De-Lens Ophthalmics
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Referring Doctor / Professional

Name……

Address……

Phone ……

Date of Exam

Patient Information

Name……

Address……

DOB……

Ph (Home): Work

Reasons for Referral

Strabismus ……

Post Brain Injury ……

Learning problems (incl. dyslexia) ……

Decrease/Lack of Stereopsis ……

Others

Amblyopia ……

Visual Stress / Headaches ……

Accommodative / Convergence Dysfunction……

Oculomotor Dysfunction……

Please explain / provide information on the above checked

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Present Rx: OD OS

Additional Information:

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Signed……

Referring Doctor……

Date……