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Minnesota Vision Therapy Center
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Vision Therapy Referral & Consultation Form

Patient Information

Name _____

DOB _____ Age _____

Home Address _____

_____

Contact Information

Parent/Guardian Name _____

Relation to patient _____

Home Phone _____

Cell Phone _____

Reason for Referral

- ☐ Strabismus / Amblyopia
- ☐ Diplopia
- ☐ Visual stress / Headaches
- ☐ Tracking difficulties
- ☐ Accommodative Dysfunction
- ☐ Convergence difficulties
- ☐ Post Trauma / Head injury
- ☐ Reduced acuities
- ☐ Learning related problems
- ☐ Perceptual issues
- ☐ ADD / ADHD

Present Rx: OD _____ 20/_____
OS _____ 20/_____

Was the Rx filled?
☐ Yes ☐ No

Additional Information _____

_____

_____

Referring Doctor / Professional

Name _____

Clinic _____

Address _____

_____

Phone _____

Email _____

To refer this patient

- ☐ Fax a copy of this form
- ☐ Fax most recent eye exam

Once the above information is received, our staff will contact the patient to schedule an evaluation within 3 business days.

A copy of the report and exam findings will be sent to the referring doctor. **We do not do general/primary eye care**. All patients will return to referring doctor's office for all general/primary eye care and glasses needs.