Allison Falden, O.D., FCOVD FAAO
Developmental Optometrist
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FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION FAX REFERRAL FORM

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

Reason(s) for Referral:

- ❑ Tracking Problems
- ❑ Strabismus/Eye Turn
- ❑ Visual Perceptual Problems
- ❑ Difficulty with Close Work
- ❑ Letter Reversals
- ❑ Autism Spectrum Disorder
- ❑ Visual Discomfort/Headaches
- ❑ Amblyopia/Lazy Eye
- ❑ Developmental Delay
- ❑ Problems with Reading
- ❑ Eye-Hand Coordination Problems
- ❑ Visual Motor Dysfunction
- ❑ Post Trauma/Stroke Evaluation
- ❑ Computer Strain
- ❑ Attention Problems, ADD/ADHD
- ❑ Head Movement while Reading
- ❑ Vestibular problems
- ❑ Other:_____

Pertinent Symptoms/ History:

I hereby grant permission for Dr. Allison Falden and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Dr. Falden so that her office can contact me (or an appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (OTR)