Focus Vision THERAPY CENTER

SCOTT R. LEWIS, O.D., F.C.O.V.D

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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:

School Problems/Dyslexia
Strabismus/Amblyopia
Convergence Insufficiency
Visual Discomfort/Headaches
AD(H)D
Convergence Excess
Post Trauma/Stroke Evaluation
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: _____

Additional information: _____

I hereby grant permission for Dr. Scott Lewis 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 Dr. Lewis so that his office can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor)

A report of testing and findings will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.