OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

TO: Dr.Shah @ Michael Mayer and Associates Optometric
ShahAakashOD@gmail.com

INTRODUCING:

Patient: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Date: _____

I am referring the above patient to your office for the following reasons:

__eye strain/headaches
__computer use
__reading/TV
__driving
__fluctuating vision
__accommodative dysfunction
__light sensitivity
__additional information/comments _____
_____
_____

__perceptual evaluation (poor school performance)
__strabismus/amblyopia
__difficulty with 3D Movies/TV
__symptomatic exophoria/esophoria
__double vision
__sports enhancement
__gross/fine motor concerns

__patient is to return to my office for eyewear needs

FROM: Referring Doctor: _____
Address: _____
Phone: _____

PLEASE FAX TO: (559) 582-2748