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NEURO OPTOMETRIC VISION EVALUATION REFERRAL/CONSULTATION FORM

REFERRAL TO: Dr. Amy Chang

Patient Information

Name ______________________________ Home Phone ______________________________

DOB ________________________________ Cell Phone ______________________________

Reason for Referral (check all that apply):

❏ Traumatic Brain Injury (TBI) ❏ Dizziness / Vertigo. ❏ Driving difficulties

❏ Stroke ❏ Headaches ❏ Peripheral vision loss

❏ Double vision ❏ Light sensitivity ❏ Visual overstimulation

❏ Depth perception issues ❏ Blurry Vision ❏ Reading difficulties

❏ Focusing / Concentration issues

Additional Information (i.e. date of injury, past ocular history):

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Referring Professional :

Name ______________________________

Fax ________________________________

Phone ______________________________

Referral for (check one):

❏ Consultation only

❏ Consultation and treatment

To refer this patient please fax a copy of this form along with relevant records. Once this information is received our staff will contact the patient to schedule an evaluation within 3 business days. A copy of the exam findings will be sent back to your office if a fax number is provided.