Alderwood
Vision Therapy Center, PLLC
TRANSFORMING LIVES THROUGH VISION

OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

REFERRAL TO: Alderwood Vision Therapy Center, PLLC
16006 Ash Way, Suite 101 Lynnwood, WA 98087
Phone: (425) 787-5200 Fax: (425) 787-5252
www.alderwoodvisiontherapy.com

PATIENT:_____
ADDRESS:_____
CITY/STATE/ZIP:_____
TELEPHONE:_____
DATE:_____

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

- ☐ Eye Strain/Headaches with:
  - ☐ Computer use
  - ☐ Reading/TV
  - ☐ Driving
- ☐ Fluctuating Acuity
- ☐ Developmental Delays
- ☐ Double Vision
- ☐ Sports Vision Evaluation
- ☐ Infant/preschool Evaluation
- ☐ Post trauma/Stroke Evaluation
- ☐ Strabismus/Amblyopia
- ☐ Accommodative Dysfunction
- ☐ Exophoria/Esophoria/Hyperphoria
- ☐ Perceptual Evaluation (Poor School Performance)

Eyeglasses RX: OD_____ 20/_____
OS_____ 20/_____

Additional Information:_____
_____
_____

REFERRAL FROM:

DOCTOR:_____
ADDRESS:_____
CITY/STATE/ZIP:_____
TELEPHONE:_____
EMAIL:_____

Alderwood Vision Therapy Center will recommend that the patient return to your office for eye wear/CL needs.(If a refraction is done in our office, per Washington law, a copy of the prescription will be provided to the patient. RCW 18.195.030)