Alderwood
Vision Therapy Center, PLLC
TRANSFORMING LIVES THROUGH VISION

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OPTOMETRIC VISION THERAPY REFERRAL 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 NAME: ____
ADDRESS:____
CITY/STATE/ZIP:____
TELEPHONE:____
DATE:____

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

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____
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REFERRAL FROM:

NAME:____
ADDRESS:____
CITY/STATE/ZIP:____
TELEPHONE:____
EMAIL:____

We often modify lens prescriptions using a behavioral approach, to aid in changes seen during the course of vision therapy. If changes to lenses or prescriptions are made, we will send updated chart notes for your records, and have the patient return to your optical for glasses or contact lens dispensing.