

## 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:					
	Eye Stı	ain/Headaches with:		Sports Vision Evaluation	
		Computer use		Infant/preschool Evaluation	
		Reading/TV		Post trauma/Stroke Evaluation	
		Driving		Strabismus/Amblyopia	
	Fluctua	iting Acuity		Accommodative Dysfunction	
	☐ Developmental Delays			Exophoria/Esophoria/Hyperphoria	
☐ Double Vision			Perceptual Evaluation (Poor School Performance)		
Eveglasses RX: OD				20/	
OS				20/	
Additional Information:					
REI	FERRAL	. FROM:			
DOCTOR:					
ADDRESS:					
CTTY/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)