Lyons Family Eye Care
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BINOCULAR VISION EVALUATION FAX REFERRAL FORM

Please send with recent eye exam records

REFERRAL CONTACT INFORMATION:	*PATIENT CONTACT INFORMATION:*
Date	Patient's Name DOB:
Referred By	Contact Information: Parent/Guardian
Address	Address
City State Zip	City State Zip
(Area Code) Phone	(Area Code) Phone Best time to call

Pertinent Symptoms/History: ______________________________

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Reason(s) for Referral:

- ☐ School/Reading Problems
- ☐ Visual Discomfort/Headaches
- ☐ Convergence Insufficiency/Excess
- ☐ Diplopia
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Asthenopia
- ☐ Other:______________________
- ☐ Post Trauma/Stroke Evaluation
- ☐ Computer Strain
- ☐ Dizziness/Vertigo

Results of Examination

Eyeglass Rx OD ______________________ VA OD ______________________
OS ______________________ VA OS ______________________

Binocular Status: ______________________ Eye Health: ______________________

Other Pertinent Results of Examination: ______________________

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I hereby grant permission for Lyons Family Eye Care and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Lyons Family Eye Care so that their office can contact me (or an appointed representative) to schedule an evaluation.

______________________ ____________ ______________________
Patient/Parent Signature Date Signature (Doctor)

A copy of all test results and a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary care and eyeglass prescriptions.