EYE See Clinic

Patient Referral Form

INTRODUCING: _____ AGE: _____ DATE: _____

PARENT/S OR GUARDIAN/S: _____

PHONE: _____

- ❏ Please call this family to set up an appointment.
- ❏ The family would like to call themselves to set up an appointment

RECOMMENDATION:

- ❏ Functional Vision Evaluation for the following concerns (check all that apply)
- ❏ Strabismus
- ❏ Amblyopia
- ❏ Anisometropia and related issues
- ❏ Concussion / TBI
- ❏ Binocular Instability - CI, CE. AS, AI, Intermittent Strab.
- ❏ Oculomotor concerns
- ❏ Vision related LD
- ❏ Body posture, orientation and stability to vision tasks - includes dizziness, motion sickness, and attention deficits
- ❏ OTHER CONCERNS / SYMPTOMS / CONDITION:

_____

REFERRING PROFESSIONAL: _____

ADDRESS: _____

PHONE: _____FAX: _____

FAX COMPLETED FORM TO: (425) 949-4491 Notes:

Check if needed:

- ❏ Please send additional referral forms
- ❏ Clinic handouts/ brochures / cards ( )

BELLEVUE	BOTHELL
★ Executive Plaza 12835 Bel-Red Road, Suite 303 Bellevue WA 98005	★ Kaufman Medical Building 18920 Bothell Way NE, Suite 203 Bothell, WA 98011