FAMILY VISION DEVELOPMENT CENTER
www.fvdcpc.com

452 N. Eola Rd. Suite D
Aurora, IL 60502
Office: 630-862-2020
Fax: 630-862-2027
Email: info@fvdcpc.com

OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

REFERRAL TO: Family Vision Development Center for
Pediatrics, Neuro-Rehabilitation, and Vision Therapies.

Patient Name:_____

Address:_____

City/State/Zip:_____

Phone: _____ Email: _____

Patient gives permission for FVDC to contact them regarding this referral:

By Phone: _____By Mail: _____ By Email: _____ Patient will call: _____

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

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

Eyeglasses RX: OD _____
OS _____

Additional Information: _____

REFERRAL FROM:

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

The Family Vision Development Center will recommend that the patient return to your office for all of their spectacle and contact lens needs.