HELLERSTEIN & BRENNER
VISION CENTER, P.C.

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OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

TO: Hellerstein & Brenner Vision Center, P.C. **DATE:** _____
Email: info@HBVision.net Fax: (303) 850 - 7032

_____

FROM:

Referring Doctor: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

INTRODUCING:

Patient Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____

City/State/Zip: _____

I am referring the above patient to your office for the following reason(s):

- □ strabismus/amblyopia
- □ convergence insufficiency
- □ symptomatic exophoria/esophoria
- □ accommodative dysfunction
- □ TBI/stroke rehabilitation evaluation
- □ double vision
- □ sports vision enhancement
- □ gross/fine motor concerns
- □ perceptual evaluation (poor school performance)
- □ eye strain/headaches with…
  - □ computer use
  - □ reading/TV
  - □ driving
- □ fluctuating vision
- □ light sensitivity
- □ additional information/comments _____

_____

_____

□ Patient is to return to my office for eyewear needs

□ Send report for co-management

□ Call patient to schedule appointment

□ *Attached are the patient's most recent examination records & other pertinent documents*