HELLERSTEIN & BRENNER
VISION CENTER, P.C.

TRICIA BRENNER, O.D. • SHELBY RILEY, O.D. • SARA GRELL, O.D. • KYARA FARINELLA, O.D. • AMY OVERLAND, O.D.

OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

Email: main@HBVision.net | Phone: (303) 850-9499 | Fax: (303) 648 - 6321

FROM:

Referring Doctor: _____ Date:_____

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*