Referral Form

For Vision Therapy and Rehabilitation

Patient Name: ______________________ **Date of Exam:** ______________________

Patient Phone: ______________________ **Patient DOB:** ______________________

Reason(s) for Referral:

☐ Difficulty reading
☐ Eye fatigue
☐ Headache
☐ Double vision
☐ Blurred vision
☐ Visual field defect
☐ Strabismus
☐ Amblyopia
☐ Head trauma
☐ Stroke
☐ Visual loss
☐ Other: ____________________________

Recommendation(s):

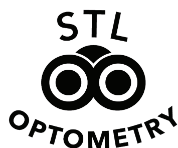
☐ Free Consultation
☐ Binocular Vision Evaluation
☐ Perceptual Skills Assessment
☐ Low Vision Evaluation
☐ Vision Therapy
☐ Sports Vision Training
☐ Myopia Control
☐ Other: ____________________________

Referring Doctor/Practice: ____

Referring Doctor's Email/Phone Number: ______________________________________

<u>Patients</u>: Please feel free to make your appointment online or call us at 650.396.3188

<u>Referring doctors</u>: Please fax over all pertinent patient records to 650.695.5917



Silicon Valley's
Advanced Vision
& Therapy Center

Staff Optometrists:
Dr. Kelly Kao
Dr. Katherine Lai
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