Referral Form

For Vision Therapy, Myopia Control, and Pediatric Care

Patient Name: ____________________ Date of Exam: _______________

Patient Phone: ____________________ Patient DOB: ________________

Reason(s) for Referral:

- ☐ Difficulty reading
- ☐ Eye fatigue
- ☐ Headaches
- ☐ Double vision
- ☐ Blurred vision
- ☐ Myopia
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Non-verbal
- ☐ Head trauma
- ☐ Stroke
- ☐ Other: ___________________

Recommendation(s):

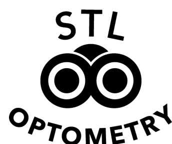
- ☐ Free Consultation
- ☐ Binocular Vision Evaluation
- ☐ Perceptual Skills Assessment
- ☐ Pediatric Eye Exam
- ☐ Vision Therapy
- ☐ Sports Vision Training
- ☐ Myopia Control
- ☐ Other: ___________________

Referring Doctor/Practice: ____

Referring Doctor's Email/Phone Number: ___________________________

***Patients:* Please schedule online OR call us at 650-396-3188.**

***Doctors:* Please fax over pertinent patient records to 650-695-5917.**



Silicon Valley's Advanced Vision & Therapy Center

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