Advanced Vision of Louisville

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FUNCTIONAL/DEVELOPMENTAL VISION EVALUATION FAX REFERRAL FORM

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Contact Information: Parent/Guardian/Hospital/Agency

Address

City State Zip

Area Code Phone Best time to call

Pertinent Symptoms/ History: _____

Reason(s) for Referral:

- ☐ School Problem
- ☐ Strabismus
- ☐ Asthenopia
- ☐ Visual Discomfort/Headaches
- ☐ Amblyopia
- ☐ Computer Strain
- ☐ Post Trauma/Stroke Evaluation
- ☐ Other:_____

Results of Examination

Eyeglass Rx OD_____ VA OD_____
OS_____ VA OS_____

Binocular Status: _____ Eye Health: _____
Other Pertinent Results of Examination: _____

I hereby grant permission for Dr. Weinberg and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Dr. Weinberg so that his office can contact me (or an appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor)

A copy of all tests results and a report will be sent to the referring doctor.
Please call Dr. Weinberg's office at (502) 894-4434 if a report has not been received in a timely fashion.
Patients will return to referring doctor's office for all primary care and eyeglass prescriptions.