OPTOMETRIC VISION THERAPY REFERRAL/CONSULTATION FORM

TO: Dr. Michael L. Serrano, O.D., P.C.

New Vision Eye Care and Rehabilitation Services

3128 Clairmont Road NE

Atlanta, GA 30329

Phone number (404) 296-6000

INTRODUCING:

Patient:

Address:

City/State/Zip:

Telephone:

Date:

I am referring the above patient to your office for the following

reasons:

__eye strain/headaches __perceptual evaluation

(poor school performance)

__computer use

__infant/preschool evaluation

__reading/TV __post trauma/stroke evaluation

__driving

__Strabismus/amblyopia

__fluctuating accuity

__double vision

__accommodative dysfunction

__exophoria/esophoria/hyperphoria

__sports vision evaluation

__developmental delays

Additional information_____

_____

__patient is to return to my office for eyewear needs

FROM:

REFERRING DOCTOR_____

ADDRESS_____

CITY/STATE/ZIP_____

PHONE NUMBER_____

EMAIL ADDRESS_____