REFERRAL REQUEST FORM

Dr Angela Sanders OD
6617 Crossings Dr. SE, Ste. 102
Grand Rapids, MI 49508
P: 616 541-7080

Referring Provider:_____

Phone: _____

PATIENT INFORMATION

Patient Name: _____ Date of birth: _____

Guardian Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

_____

Date of Exam: _____ Rx Given (if any) OD: _____

Dilation: Yes / No Cyclo: Yes / No OS: _____

Diagnosis: _____

Pertinent Exam Findings / Patient History: _____

_____

_____

REASON FOR REFERRAL

Neuro/Ocular

❒ Strabismus
- ❖ ESO / EXO
- ❖ Large / Medium / Small
- ❖ Alternating / OD / OS

❒ Amblyopia
- ❖ VAs: OD / OS
- ❖ Suppression: Yes / No

❒ Convergence Dysfunction

❒ Accommodation Dysfunction

❒ Visual Stress Headaches

❒ Acquired Brain Injury
(Visual Snow / Smear, Motion Sickness)

❒ Other: _____

Vision Related Learning Problems

❒ ADD / ADHD

❒ Reading Comprehension

❒ Spelling / Handwriting

❒ Intellectual / Developmental Delays

❒ Autism Spectrum Disorder

❒ Sensory Integration Disorder

❒ Motor Delays

❒ Other: _____

Please fax this form to 616 541-7088 or call to schedule an appointment
Feel free to attach additional information

ACADEMY OF VISION DEVELOPMENT