PROSPER FAMILY EYECARE

OPTOMETRIC VISION THERAPY REFFERAL/CONSULATION FORM

Referral to: Prosper Family Eyecare
Kelvin Van Voorst, OD and Stacie Van Voorst, OD
110 N. Preston Rd, Ste 30 Prosper, TX 75075
Phone: 972-347-2004 Fax: 972-347-3847 Email: info@prosperfamilyeyecare.com

Patient:_____Date of Birth: _____

Phone: _____Date: _____

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

- ☐ Eye Strain/Headaches with:
  - ☐ Computer use
  - ☐ Reading/TV
  - ☐ Driving
- ☐ Fluctuating Acuity
- ☐ Developmental Delays
- ☐ Double Vision
- ☐ Post trauma (concussion) Evaluation
- ☐ Strabismus/Amblyopia
- ☐ Accommodative Dysfunction
- ☐ Exophoria/Esophoria/ Hyperphoria
- ☐ Perceptual Evaluation (poor school performance)

ADDITIONAL INFORMATION:

_____

_____

_____

_____

EYEGLASSES RX:

OD:_____ 20/ _____

OS: _____ 20/_____

REFERRAL FROM:

Doctor:_____Practice Name:_____

Address: _____

Phone: _____Email:_____

Prosper Family Eyecare will recommend that the patient return to your office for eyewear and contact lens needs.