

## Therapist Referral for Evaluation

Referring Therapist: \_\_\_\_\_ Referring Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_  
\_\_\_\_\_ Home Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Email: \_\_\_\_\_

### Diagnosis:

- Post-Concussive Vision Syndrome
- Convergence Insufficiency
- Diplopia
- Oculomotor Dysfunction
- Accommodative Dysfunction
- Visual Field Loss
- Visual-Motor Dysfunction
- Developmental Delays
- Amblyopia
- Strabismus
- Autism
- ADD / ADHD

### Symptoms:

- Double Vision
- Transient Blur
- Headaches
- Motion Sickness
- Dizziness
- Vision Fatigue
- Letter Reversals
- Poor Concentration
- Slow Reading Speed
- Poor Reading Comprehension
- Poor Visual Memory
- Poor Visual Processing
- Poor Handwriting
- Poor Eye-Hand Coordination
- Light Sensitivity
- Visual Spatial Confusion

### Additional Notes:

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#### Grand Rapids



#### St. Joseph

