EYES ON MAIN

PEDIATRIC EYE EXAM REFERRAL

Patient information: Name (First, M.I., Last)_____

Birth date (MM/DD/YYYY)_____ Primary language _____ E-Mail _____

Mailing address _____ City _____ State ____ Zip _____

Primary phone ( )____- _____ Secondary phone ( )____- _____

Referring agency contact information and reason for referral:

Office name _____ Phone number ( ) ____-_____

Fax number ( ) ____-_____ E-Mail _____

Date of referral _____ Vision screening conducted by_____

Reason for referral (Check all that Apply):

____ Visual acuity (___Distance ___Near ___Both)

____ Misaligned eyes

____ Pupillary reflex

____ Red reflex

____ Ocular structure concern (i.e., ptosis (drooping eyelid)

____ Family history of early onset vision problems

____ Developmental delay/chronic condition (describe) _____

____ Other (describe) _____

Exam results from Dr. Loren Rodgers:

Date of eye examination: _____

Best visual acuity		**Info Vision Screening Agency Should Know/Do**
Right	Left	
_____	_____	

Check if appropriate:

- ☐ Treatment recommended
  - Medical: _____
  - Glasses
  - Contact Lenses
  - Other: _____
- ☐ Corrective lenses prescribed
  - Constant wear
  - For near only
  - For distance only
- ☐ Hyperopia
- ☐ Myopia
- ☐ Astigmatism
- ☐ Anisometropia
- ☐ Amblyopia
  - Patching recommended _____ hrs daily
- ☐ Strabismus
- ☐ Low vision evaluation/assistance recommended
- ☐ Re-examination advised
  - With 6 months
  - Within 12 months
  - Other: _____
- ☐ Other: _____

_____

Eyes on Main Provider contact information:

ECP Name_____ Phone( )____-_____ Fax ( )____-_____

Address _____ City _____ State ____ Zip _____

EYES ON MAIN APPRECIATES YOUR REFERRAL AND WOULD LIKE TO OFFER 10% OFF MATERIALS FOR YOUR PATIENT! (INCLUDES COMPLETE SET OF PRESCRIPTION GLASSES/SUNGLASSES, PLANO SUNGLASSES, OR 1 YEAR SUPPLY OF CONTACTS)