Northwest EyeCare PROFESSIONALS

Referral form

Northwest VISION ACADEMY

Please fax to: Northwest Vision Academy, ATTN: Taylor McGann, OD
Fax #: 614-486-0354

**Required Fields*

Referring Provider's Name/Practice*:

Referring Provider's phone number*:

Referring Provider's fax:

Referring Provider's specialty:

- ☐ Optometrist
- ☐ Primary Care Physician
- ☐ Ophthalmologist
- ☐ Occupational Therapist
- ☐ Neurologist
- ☐ Physical Therapist
- ☐ Speech Therapist
- ☐ Other_____

Patient Name*:

Date of birth*:

Parent name (if child):

Patient/parent phone number*:

Patient/parent email:

Diagnosis/area of concern:

- ☐ Accommodative dysfunction
- ☐ Vergence dysfunction
- ☐ Saccade/oculomotor problem
- ☐ Visual perceptual evaluation
- ☐ Eye strain
- ☐ Poor school performance
- ☐ Strabismus
- ☐ Infant/Preschool Evaluation
- ☐ Post-concussion Evaluation
- ☐ Traumatic Brain Injury
- ☐ Headaches
- ☐ Diplopia
- ☐ Amblyopia
- ☐ Other_____

Comments: