Beyond 20/20
Vision Therapy

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Patient Name: _____ **DOB:** _____
If Minor, Guardian's Name: _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #1: _____ **Phone #2:**_____
Insurance: _____

Referring Doctor: _____
Office: _____
Office Address: _____**City:** _____ **State:** ____ **Zip:** _____
Phone #: _____ **Fax #:** _____

Reason for Referral: _____
_____
_____

Most Recent Refraction:
Date: ___/___/____ OD _____ 20/ OS _____ 20/

Diagnosis (if known):

- ▢ Convergence Insufficiency
- ▢ Convergence Excess
- ▢ Accommodative Issue
- ▢ Amblyopia
- ▢ Exotropia - OD OS Alt
- ▢ Esotropia - OD OS Alt
- ▢ Binocular Vision Disorder
- ▢ Perceptual/Learning Disorder
- ▢ Other _____

Anterior Ocular Health:

- ▢ Unremarkable
- ▢ Abnormal

Posterior Ocular Health:

- ▢ Unremarkable
- ▢ Abnormal

Please explain abnormal ocular health: _____
_____

Doctor's Signature: _____ **Date:** _____
**Progress reports will be sent to your office as the patient progresses with therapy. Once treatment is completed, your patient will return to you for all primary eye care.