Summit Vision Center
PEDIATRIC EYE CARE + VISION THERAPY

Tina Schiller, OD, FCOVD | Katie Hash, OD, FCOVD
P: (425) 276-0388 / F: (425) 276-0387
970 5th Ave NW, Ste 120 / Issaquah, WA 98027
info@summitvisioncenter.com

PROVIDER REFERRAL FORM

Like you, caring for patients and their vision is our priority! If you want to connect directly with us for any reason, we would love to hear from you. Feel free to email us or call our office.

Provider Name: Office Name:

Office Phone Number: Office Fax Number:

Patient Name: Patient Date of Birth:

Patient Phone Number:

Reason for Referral (check all that apply):

__ Failed Vision Screening
__ Blurred Vision
__ Eye Strain / Headaches
__ Double Vision
__ Brain Injury / Stroke
__ Attention and/or Reading Problems
__ Strabismus/Amblyopia
__ Dizziness / Motion Sensitivity
__ Eye Tracking or Teaming
__ Pediatric Vision Evaluation
__ Myopia Management
__ Other: _____

Comments / Additional Information:

For eye care professionals only

Date of Exam _____

Refraction: OD _____ VA 20/____ OS _____VA 20/____
__ cycloplegia deferred

__ Check here if you are waiting for your patient's consultation with us to finalize their glasses or contact lens prescriptions. We will fax their finalized prescription to your office so that they can complete their eyewear or contact lens order.