Summit Vision Center
PEDIATRIC EYECARE + VISION THERAPY

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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.