Visual Edge LLC
227 Church Street, Phoenixville, PA 19460
610-933-5137 (fax) 610-933.5126

Referral for Evaluation

Patient Information

Name_____
Address _____
_____
Age_____ Grade/Job_____

Contact Information

Parent/Guardian Name_____
Relationship to Patient _____
Phone _____
e-mail_____

Visual Edge should: ○ Contact patient to schedule an evaluation
○ Wait for patient to call

☐ *Learning Difficulty* ☐ *Diplopia/Double Vision* ☐ *Myopia Management Assessment*

☐ *Headaches* ☐ *Decreased Vision* ☐ *Accommodative Dysfunction*

☐ *Convergence* ○ *Insufficiency* ○ *Excess* ☐ *Oculomotor Dysfunction* ○ *Pursuits* ○ *Saccades*

☐ *Divergence* ○ *Insufficiency* ○ *Excess* ☐ *Amblyopia* ○ *Refractive* ○ *Strabismic*

☐ *Strabismus / Eye Turn:* ○ *Eso* ○ *Exo* ○ *Vertical* ○ *Constant* ○ *Intermittent*

☐ *Post-Concussion Vision Syndrome: Date(s) of mTBI*_____

☐ *Other* _____

Additional Information: _____
_____
_____
_____

Referred By: _____

School/Office Of _____ Address: _____

Position:_____ _____

_____ Phone: _____

Preferred Method of correspondence: Fax: _____

○ Fax ○ Mail ○ e-mail e-mail: _____

Please fax form to 610-933-5126 or email to MyVisualEdge@gmail.com