

## Fax Referral Form Patrick J. Pirotte, OD Ann Marie Sparacino OD

746 N. Maize Road, Suite 200 Wichita, KS 67212 Telephone: (316) 722-3740 Fax: (316) 722-3807

The 3 steps to refer a patient for a developmental vision evaluation:

- 1. Patient or parent fills out the top portion and signs. Please tell the patient that our office will call to schedule the additional testing.
- 2. The referring doctor fills out the bottom portion.
- 3. Please fax this form to (316) 722-3807. Keep the original for your files. Thanks!

Patient Information:						
Patient's Name	DOB		Age	Address		
If minor child, parent whom we should contact				City/State	Zip	
What is the best time of day to reach you?				Telephone number to ca	all	
					nt. I also grant permission for my eye doctor ts, diagnoses, case history, etc.	
X						
Patient/Parent Signature				Date		
	Exami	inatio	n Results fro	om Referring Docto	)r:	
Patient's Pertinent Sy  Reason(s) for Referr  Binocular disc	al:		Strabismus		Post Trauma/Stroke evaluation	
☐ Accommodation			Amblyopia		Computer Strain	
<ul><li>☐ Tracking</li><li>☐ Reading or att</li></ul>	ention problems		Headaches Asthenopia		Low Vision Other	
Eyeglass Rx OD				VA 0	D	
OS				VA O	S	
Eye Health:						
Other Pertinent Resul	ts of Examination:					
				X		
Doctor's Name (please print)				Doctor's Signature		
Address				Date		
City/State		7	Zip	Office Telephone		

A copy of all test results and a report will be sent to the referring doctor. Patients will return to referring doctor's office for all primary care and eyeglass prescriptions.