



EagleEye Performance Vision
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Patient Name: _____ D.O.B: _____

Patient Phone Number: _____

Parent's/Guardian's Name(s) if applicable: _____

Referring OT: _____ Date of Referral: _____

Referring OT Phone # : _____ Fax #: _____

Referring OT Email: _____

Reason for Referral:

- Traumatic Brain Injury Rehabilitation
- Stroke Rehabilitation
- Baseline Concussion Testing
- Headaches
- Balance, Motion Sickness
- Double Vision
- Blurry Vision
- Eyestrain
- Tracking & Eye Movement Related Problems
- Reduced Comprehension, Memory
- Light Sensitivity
- Depth Perception
- Sports Vision Evaluation
- Other: _____

Thank you for your kind referral and consideration. Our office will send you a full report upon completion of the evaluation. We look forward to joining in the care of this patient.