EagleEye Performance Vision
Neil Renaud, OD, FAAO, FCOVD
Claire Michel, OD
8516 Homestead Dr. Ste 106
Zeeland, MI 49464
Ph: 616.848.7548
Fax: 616.848.7558
Info@EagleEyeVisionTherapy.com

Patient Name:______________________ D.O.B: ______________

Patient Phone Number: ______________________________________

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

Referring PT: ______________________ Date of Referral: __________

Referring PT Phone #: ________________ Fax #: ______________

Referring PT 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.