EagleEye Performance Vision
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Student's Name: ______________________ D.O.B: ______________

Parent/Guardian Phone Number: ______________________________

Parent/Guardian Name(s) : ______________________________

Referring Teacher: ______________________ Date of Referral: __________

Referring Teacher Phone # : ______________ Fax #: ______________

Referring Teacher Email: ______________

Reason for Referral:

❑ Schoolwork Takes Excessive Time
❑ Short Attention Span
❑ Holds Books/Screen Very Close
❑ Difficulty Copying Notes In Class
❑ Skips/Repeats Lines While Reading
❑ Difficulty Remembering Known Words
❑ Must Re-Read For Comprehension
❑ Choppy Reading Fluency
❑ Blurry/Double Vision
❑ Rubs Eyes Or Blinks A Lot
❑ Poor Handwriting
❑ Inaccurate Eye-Hand Coordination
❑ Other: ______________________________

Thank you for taking this extra step to help this student. Our office will send you a full report upon completion of the evaluation. We look forward to joining in the care of this student.