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

# Vision Therapy Referral

Patient Name: _____ D.O.B: _____

Patient Phone Number: _____

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

Referring Doctor: _____ Date of Referral: _____

Referring Dr. Phone # : _____ Fax #: _____

**Reason for Referral:**

❑ Convergence Insufficiency
❑ Binocular Dysfunction
❑ Accommodative Dysfunction
❑ Oculomotor Dysfunction
❑ Amblyopia
❑ Strabismus
❑ Learning Related Difficulties
❑ Traumatic Brain Injury/Concussion
❑ Stroke Rehabilitation
❑ Myopia Management
❑ Sports Vision Evaluation

RX If Prescribed: **Therapeutic lenses might be prescribed, we suggest to keep a new lens order on hold until confirmed.**

OD:

OS:

***Thank you for your kind referral. We will call the patient to go over all details and questions before scheduling. Our office will send you a full report upon completion of the evaluation. We look forward to joining in the care of your patient.***