# UNIVERSITY OF CALIFORNIA, BERKELEY

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SANTA BARBARA • SANTA CRUZ

CHILDREN'S VISION and NEURO-OPTOMETRY
SCHOOL OF OPTOMETRY
BERKELEY, CALIFORNIA 94720-2020
Voice 510.642.2020

## REFERRAL FORM
## BINOCULAR VISION CLINIC
**Appointments: (510) 642-2020 / Fax: (510) 642-8012**

**Referring Dr:** **Name:** **Phone:**

**Street:** **City:** **ZIP:**

**Fax:** **email:**

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**Patient:** **Name:** **Date of Birth: / / Age:**

**Street:** **City:** **ZIP:**

**Home Phone:** **Work Phone:**

**Cell Phone:** **email:**

**If a minor, Parents' Name(s):** **Phone:**

**If different address:**

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**TYPE OF SERVICES REQUESTED:**

**[ ] Binocular Vision Evaluation = Full and comprehensive evaluation, two 90 minutes visits**

**[ ] Strabismus/Amblyopia/Nystagmus Evaluation = Full and comprehensive evaluation = two x 90 min**

**[ ] Head injury or Stroke evaluation = Neuro-optometric evaluation = two or three x 90 minutes**

**[ ] Perceptual Skills Assessment = 3 or 5 visits depending upon age and difficulties, in addition to initial binocular vision evaluations**

**[ ] Informal Reading Evaluation = 3 visits**

**[ ] Visual Therapy (Orthoptics) = 8 sessions/ block. Require a binocular evaluation prior to start of therapy.**

**[ ] Perceptual Training = Patient require perceptual skills analysis prior to therapy = 8 sessions per block**

**[ ] Amblyopia management = Patient require binocular vision evaluation prior to treatment = monthly and quarterly follow up appointments for at least 18 months.**

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**Should your patient see a particular doctor? [ ] No [ ] Yes**

**If yes, please indicate whom:**

**Staff Drs: ( ) Hoenig ( ) Chester ( ) Lee ( ) Wu ( ) Fisher (Lim)**

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**Specific Information Requested: (*A short written report will be sent to your office address*).**

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**Would you like to assist in treatment? (if needed):**

**[ ] No [ ] Yes; If yes, to what extent?**

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**Please turn for patient information**

**Patients Name:** _____

**[ ]** **Please obtain UCBSO –BV patient information/ welcome package**

**[ ]** **Please review and fill out the following forms (if applicable)**

- **[ ] Welcome to Clinic**
- **[ ] Developmental History**
- **[ ] Confidential Medical History**
- **[ ] Consent to Communicate Via Email**
- **[ ] Notice of Privacy Practices**
- **[ ] Policies for Vision Therapy & Training Equipment**
- **[ ] Directions to the University Eye Center**

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**Patient's history and chief complaint:**

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**Present glasses or C.L.'s:** **Date:**

**OD:** **OS:**

**Add:** **Prism or IPD:**

**VA with Rx:** **OD:** **OS:** **VA without Rx:** **OD:** **OS:**

**Most recent refraction:** **OD:** **VA: (dist.)** **VA: (near)**

**Date:** **OS:** **VA: (dist.)** **VA (near)**

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**Binocular Vision Findings:**

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**Oculomotor Findings:**

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**Ocular Health Findings:** **[ ] Dilation performed with _____** **[ ] No dilation performed**

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**Other pertinent information:**

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**Doctor Signature**