# Center for Better Learning

Better Vision. Brighter Future.

## Christina Murray OD, FCOVD

Developmental Optometrist

### Patient Information:

Name:___________________________________

DOB:____________________ Age:___________

### Contact Information:

Parent/ Guardian Name:___________________

Phone Number: __________________________

Email:___________________________________

### Reason for Referral:

- ☐ Amblyopia/Strabismus
- ☐ Eye Tracking Difficulties
- ☐ Convergence/Divergence Insufficiency
- ☐ Post-Concussion/Head Trauma
- ☐ Poor School Performance
- ☐ Double Vision
- ☐ Dizziness/Vertigo
- ☐ Other: __________________________

### Additional Information:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

### Referring Professional:

Name:___________________________________

Profession: ______________________________

Clinic:___________________________________

Phone Number: __________________________

Fax Number: _____________________________

Email:___________________________________

### *To refer this patient...*

- ☐ Fax/email a copy of this form
- ☐ Fax/email any relevant records

We will contact the patient directly to schedule an evaluation.

Reports and treatment plans will be sent following evaluation.

We are a vision therapy only practice. We do not perform any primary eye care services.


**www.CenterforBetterLearning.com**

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