Center for Better Learning

Better Vision. Brighter Future.

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Ph: (561) 462-1245

Patient Information:

Name:_____

DOB:_____ Age:_____

Home Address: _____

_____

Contact Information:

Parent/ Guardian Name:_____

Relationship to Patient:_____

Phone Number: _____

Email:_____

Reason for Referral:

- ☐ Amblyopia / Strabismus
- ☐ Learning Related Visual Problem
- ☐ Post Concussion/ Head Trauma
- ☐ Eye Tracking/ Teaming Difficulties
- ☐ Double Vision
- ☐ Headaches
- ☐ ADD/ ADHD
- ☐ Visual Stress

Additional Information:

_____

_____

_____

Referring Professional:

Name:_____

Clinic:_____

Address: _____

_____

Phone Number: _____

Email:_____

To refer this patient...

- ☐ Fax a copy of this form
- ☐ Fax 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 general/ primary eye care.