Date: _____

To: Beth Munzel, OD at The Vision Therapy Studio
2061 Beechmont Avenue Unit C
Cincinnati, OH 45230 (513) 232-9555 Fax: (513) 232-0400

Referring Doctor or Professional:

Name_____

Address:_____

City/State/Zip_____Phone:_____

Fax:_____

Patient:_____DOB:_____

Address:_____

City/State/ZIP_____Phone:_____

Parent Name (if child):_____

_____ Please call patient to schedule evaluation _____ Patient will call to schedule

I am referring the above patient to your office for the following reasons:

_____ Perceptual Evaluation (Poor school performance) _____ Eye Strain/Headaches

_____ Convergence Issue _____ Infant/Pre-school Evaluation

_____ Saccade/eye movement concern _____ Fluctuating Acuity

_____ Post Trauma/Stroke Evaluation _____ Accommodative Dysfunction

_____ Strabismus/Amblyopia

Additional Information_____

_____

_____

Thank you for the kind referral. I'll correspond with you as soon as I am able.