Nahrain M. Shasteen, OD, MS, FAAO

Patient Referral Form

Patient Demographics

Name: ____ Date of Birth_____________________

Home Address: ____

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Parent/Guardian____

Relationship to Patient: ____________________________ Phone Number: ________________

Reason for Referral

□ Strabismus/Eye Turn	□ Amblyopia/Lazy Eye	□Double Vision/Diplopia
□ Headaches/Eye Strain	□ Tracking Difficulties	□ Accommodative Dysfunction
□ Convergence Difficulties	□ Post Trauma/Head Injury	□ Learning Related Problems
□ Perceptual Issues	□ Blurred Vision	□ Poor Eye-Hand Coordination

Has the patient had a complete dilated eye exam within the last 6 months? □ Yes □No

Additional Information (please list current glasses RX if known):

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Referring Doctor/Professional

Name: ____________________________________ Practice: ____________________________

Address: ____

Phone: ___________________________________ Fax: ________________________________