Referral for Vision Services

Alphapointe and KC Vision Performance
Phone: (816) 237-2020
Fax: (816) 237-2065

Patient name: _____DOB:_____

Telephone: (_____) _____

Reason for Referral:

- ○ Low Vision Evaluation/Services
- ○ Occupational Therapy Evaluation/Services
- ○ Neuro-Optometry Evaluation/Services
- ○ Vision Therapy Evaluation/Services

Functional difficulties due to vision (check all that apply):

□ Reading, writing, homework

□ ADL's (activities of daily living)

□ Getting/Keeping a job

□ Moving around safely (falling)

□ Moving around safely (falling)

□ Driving

□ Other _____

***Please fax the following with referral: Copy of Last office visit note, including visual fields (if available), demographics and insurance information.**

Referring Doctor/Person: _____

Referring Agency: _____

Telephone: (___) _____FAX: (__) _____