See The Light
OPTOMETRY

*Silicon Valley's Advanced Vision Therapy Center*

# *Referral Form*

## For Vision Therapy, Rehabilitation, Pediatric Care

Patient Name: _____ Date of Exam: _____

Patient Phone: _____ Patient DOB: _____

**Reason(s) for Referral:**

- ☐ Difficulty reading
- ☐ Eye fatigue
- ☐ Headaches
- ☐ Double vision
- ☐ Blurred vision
- ☐ Visual field defect
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Head trauma
- ☐ Stroke
- ☐ Vision loss
- ☐ Other: _____

**Recommendation(s):**

- ☐ Free Consultation
- ☐ Binocular Vision Evaluation
- ☐ Perceptual Skills Assessment
- ☐ Pediatric/Special Needs Eye Exam
- ☐ Vision Therapy
- ☐ Sports Vision Training
- ☐ Myopia Control
- ☐ Other: _____

Referring Doctor/Practice: _____

Referring Doctor Contact Information: _____

***Patients:*** *Please schedule online OR call us at* **650-396-3188**.

***Doctors:*** *Please fax over pertinent patient records to* **408-685-2133**.


*See the Light Optometry*
333 W El Camino Real Ste 265
Sunnyvale, CA 94087
Phone: 650-396-3188
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*Vision Therapy Center overseen by Dr. Kelly Kao with 1:1 doctor-directed vision therapy*


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