Dr. Fred Edmunds
Sports Vision Optometrist

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► SPORTS / PERFORMANCE VISION EVALUATION REFERRAL FORM ◄

Date

Referred By

Address

City State Zip

Area Code Phone

Patient's Name Age

Primary sport Position

Contact Information: Parent/Guardian

Address

City State Zip

Area Code Phone Best time to call

Relevant symptoms / history: _____

Reason(s) for referral:

- ❑ Competitive athlete looking for visual edge
- ❑ Desires contact lenses for sport
- ❑ Visual discomfort / headaches / eye strain
- ❑ Inconsistent performance on field of play
- ❑ Visual concentration difficulties
- ❑ Amblyopia / strabismus
- ❑ Convergence insufficiency/excess
- ❑ Other _____

Results of Examination:

Spectacle / CL Rx: OD _____ VA _____
(circle) OS _____ VA _____

Binocular status: _____

Ocular health: _____

Other pertinent results: _____

I hereby grant permission for Dr. Fred Edmunds, and any other practitioner involved in my vision care, to exchange information concerning my case history, results of examination, diagnoses, treatment, etc.
I hereby give permission to have this information faxed or mailed to Dr. Edmunds so that he may contact me to schedule an appointment for a comprehensive visual performance evaluation.

Patient/Parent Signature Date Signature (doctor)

A copy of the visual performance evaluation and performance vision training final report will be sent to the referring doctor. Patients will return to referring doctor's office for primary care and/or spectacle prescriptions.