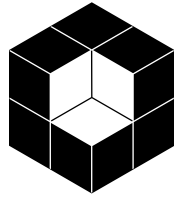


Louisville Location
3701 Hopewell Rd Ste 900
Louisville, KY 40299
(502) 398 - EYES



BOWERSOX
VISION CENTER

Shelbyville Location
403 Washington St.
Shelbyville, KY 40065
(502) 647- EYES

Bowersox Vision Center Referral Form

Fax to: 502-633-7326 for Both Locations

Or Online: www.drbowersox.com/online-referral-form/

_____	_____	_____	_____
Date	Patient's Name	Age	D.O.B.
_____	_____	_____	_____
Referred By	Parent name (if applicable)/ Email		
_____	_____		
Address	Address		
_____	_____		
City	State	Zip	
_____	_____	_____	
Phone	Fax	Phone	Best time to call
_____	_____	_____	_____

Symptoms/Conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Convergence Problems | <input type="checkbox"/> Problems with Attention | <input type="checkbox"/> Trouble copying from board |
| <input type="checkbox"/> Strabismus/Amblyopia | <input type="checkbox"/> Visual Perceptual problem | <input type="checkbox"/> Balance evaluation |
| <input type="checkbox"/> Refractive Error | <input type="checkbox"/> Post Stroke | <input type="checkbox"/> Long term drug therapy with ocular side effects |
| <input type="checkbox"/> Diplopia | Evaluation/Visual field | <input type="checkbox"/> Visual Evoked Potential |
| <input type="checkbox"/> Headaches/Eyestrain | <input type="checkbox"/> Post Trauma/ABI | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Tracking Problems | <input type="checkbox"/> Poor Handwriting | |

Additional Information (including if you are referring to a specific doctor): _____

***BVC will call patient to set up appointment.**

****Please attach a copy of your examination/records/diagnoses/glasses Rx if applicable.**

ATTENTION: PATIENT & REFERRING DOCTOR – PLEASE REVIEW THIS PARAGRAPH & AUTHORIZE BELOW:

I hereby grant permission for Bowersox Vision Center to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I also hereby give permission to have this information faxed to Bowersox Vision Center so they can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature

Date

Doctor's Signature

Date