**Midtown Vision Development Center**
*Better Learning Through Better Vision*

**Nicole Sangani (Cumella), OD, FAAO**
**551 Fifth Avenue, 2nd Floor**
**New York, NY 10176**
**Office: (212) 265-4609**
**Fax: (212) 382-2123**
**midtownvdc@gmail.com**

## VISION THERAPY REFERRAL FORM

**Please fax this referral form to (212) 382-2123 or mail to address above**

Date_____ Patient Name _____ M / F

DOB_____ Parent/Guardian Name _____

Contact number/email: _____

**Eye Examination History (For Optometrist/ Ophthalmologists only):**

Last eye exam:_____/_____/_____
Last DFE: _____/_____/_____ Ocular Health: □ Unremarkable OD and OS □ Other _____
Glasses/CL Rx & BCVAs:
□ No Rx
□ Rx:
Right Eye_____ VA_____
Left Eye:_____ VA_____

**Reason for referral for a Vision Therapy Evaluation/Treatment:**

□ Visual processing Deficits
□ Learning Related Vision Problems
□ Ocular Motor Dysfunction (Eye Tracking)
□ Accommodative Dysfunction (Eye Focusing)
□ Binocular Vision Dysfunction (Eye Teaming)
□ Amblyopia (Lazy Eye)
□ Esotropia (ET)
□ Exotropia (XT)
□ Eso/Exo Phoria (EP/ XP)
□ Convergence Insufficiency
□ Convergence Excess
□ Hyper/Hypo Tropia
□ Concussion/ Neuro-Visual Rehabilitation
□ Sports Vision
□ Myopia Control
□ Other_____

Notes:
_____
_____
_____
_____

REFERRING PROVIDER: _____
REFERRING LOCATION: _____
PHONE NUMBER: _____
FAX: _____
EMAIL: _____