Eye Priority RE-Vision, P.C.

Rehabilitation and Enhancement

Kelly de Simone, OD, FCOVD

Patient Name: _____ Age: _____

Patient's Parent/Guardian Name: _____

Patient Phone: _____ Date of Birth: _____

Patient's Email Address: _____

Patient's Complaint and Significant Findings: _____

_____

_____

Date of Last Comprehensive Exam (Attach Record): _____

Reason for Referral (Please Circle):

Accommodative dysfunction	Sports vison/sports related
Amblyopia	Difficulty with concentration
Binocular dysfunction	Memory loss
Concussion	Headaches
Convergence insufficiency	Fatigue
Nystagmus	Double vision
OMD pursuits	Pain in or around the eyes
OMD saccades	Head tilt
Strabismus	Impaired balance
Stroke	Difficulty maintaining eye contact
Suppression	Diminished comprehension
Visual field loss	Visual field neglect

Difficulty with eye movements, such as tracking, shifting gaze, or focus

Other:

Referring Doctor: _____ Date Referred: _____

Address: _____

Phone Number: _____ Fax Number: _____

15725 S 46th Street Suite 112 Phoenix, AZ 85048 (480) 893-3999

Please fax to: (480) 297-0503

Or email to vtinfo@eyepriority.com