VISION REFERRAL FORM

The Akron Children's Hospital Vision Center is pleased to be able to offer the following outpatient visual system testing services. This form must be completed in full and signed by the referring physician. Completed forms should be email to VisionCenter@AkronChildrens.org After sending, please call our scheduling desk at 330-543-5290 to schedule this appointment.

Patient Name:_____DOB:_____

Parent/Guardian Name:_____

Patient Address:_____

City_____State_____Zip_____County_____

Insurance Carrier's Name:_____DOB:_____

Address:_____

City_____State_____Zip_____

Reason for Referral:_____

Surgery Referral: _____

Is Referral **Routine/Urgent/Stat?** If stat, please call our office at 330-543-5290 and ask to speak with a nurse.

Please select any testing you would like completed during the visit:

☐	A-Scan	☐	B -Scan
☐	Contrast Sensitivity	☐	Color Vision Extended
☐	Eye Movement Recordings (EMR)	☐	Electroretinography (ERG)
☐	Photography –Ext Ocular	☐	Photography-Fundus
☐	Visual Field Testing	☐	Sensorimotor/Extended EOM
☐	Visual Evoked Potential (VEP)	☐	Other (if available):
☐	Corneal Topography (Pentacam)	☐	Fluorescein Angiography

Comments/Precautions

Referring Physician
(Print):_____Phone/Fax_____