



VISION REFERRAL FORM

The Akron Children's 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 faxed to 330-543-5292 or emailed 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: _____ Phone number: _____

Patient Address: _____

City _____ State _____ Zip _____ County _____

Insured name: _____ DOB: _____

Benefits provider name: _____

Full address: _____

Group #: _____ Member I.D.: _____

Reason for Referral: _____

Surgery Referral: _____

If referral is urgent or 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 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 |
| ☐ Corneal Topography (Pentacam) | ☐ Fluorescein Angiography |

Comments/Precautions:

Referring Physician

(Print): _____ Phone/Fax _____