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VisionQuest EYECARE

TreeHouse Eyes Myopia Treatment Referral Form

Available online at visionquesteyecare.com

Patient's Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____ Patient Gender: **M** **F**

Email Address: _____ Phone Number: _____

Ethnicity: **Asian** **Black or African American** **Latino / Hispanic** **Caucasian** Other: _____

The patient's parents have had their questions answered regarding the consequences of treating vs. not treating their child's Myopia (for example: possible eye health implications of increasing Myopia). **Yes** **No**

The above patient has been myopic for approximately _____ year(s).

Parents myopic? **Yes** **No** **Who?** **Mother** **Father**
Siblings myopic? **Yes** **No** How many myopic siblings does the patient have? _____

Current Subjective RX: OD: _____ 20/_____ OS: _____ 20/_____
Date Prescribed: _____/_____/_____

Previous RX: OD: _____ OS: _____
Date Prescribed: _____/_____/_____

Estimated Digital Device Use: _____ hours / day Estimated Time Spent Outdoors: _____ hours / day

Referring Doctor (print): _____ Practice Name:_____

Email Address: _____

Do you intend to co-manage? **Yes** **No**
Do you need a Vision Therapy Evaluation? **Yes** **No**
Preferred Office: **Greenwood** **Geist**
Comments:

Greenwood
1160 North State Rd. 135
Greenwood, IN 46142
P:(317)865-6829
F: (317)886-7655

Treehouse Eyes
MYOPIA CARE FOR KIDS

Geist
13840 East 96th Street
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