Referral for Vision Services

Cal Wiese, OD and Emily Kyle, OD
Alphapointe and KC Vision Performance
Phone: (816) 237-2020 Fax: (816) 237-2065

Patient name: _____ DOB: _____

Telephone: (_____) _____ Text: YES NO

Alternate contact and phone #: _____

Email: _____

Reason for Referral (Please choose one):

- Low Vision Exam & Occupational Therapy Evaluation for ADL's
- Neuro-Optometry Vision Evaluation/Services
- Child Developmental Vision Evaluation/Services

Please send the following with this form:

*** Last office note & annual eye exam**

*** Visual fields (if applicable)**

*** Demographics**

*** Insurance information**

*Note: All of the above information is needed for scheduling.

Referring Doctor/Professional: _____

Referring Office/Agency: _____

Telephone: _____ FAX: _____