Referral for Vision Services

Alphapointe and KC Vision Performance
Phone: (816) 237-2020
Fax: (816) 237-2065 | Email: lowvisionclinic@alphapointe.org

Patient name: _____DOB:_____

Telephone: (_____) _____

Reason for Referral:

- ☐ Low Vision Evaluation/Services
- ☐ Occupational Therapy Evaluation/Services
- ☐ Neuro-Optometry Evaluation/Services
- ☐ Vision Therapy Evaluation/Services

Functional difficulties due to vision (check all that apply):

□ Reading, writing, homework □ ADL's (activities of daily living)

□ Getting/Keeping a job □ Moving around safely (falling)

□ Moving around safely (falling) □ Driving

□ Other _____

***Please fax the following with referral: Copy of Last office visit note, including visual fields (if available), demographics and insurance information.**

Referring Doctor/Person: _____

Referring Agency: _____

Telephone: (___) _____ FAX: (__) _____