University Eye Center
FERRIS STATE UNIVERSITY

Referral to UEC Pediatrics & Binocular Vision Service

Patient Name _____ **DOB** _____

Parent/Guardian Name _____

Patient Phone Number_____ **Referring Physician** _____

Office Name _____

Address _____

Office Phone Number_____ **Fax** _____

Would you like us to call and schedule your patient? ☐ **Yes** ☐ **No**

Reason for Referral (check all that apply):

Visual Efficiency Evaluation

☐ Strabismus
☐ Amblyopia
☐ Accomm./Vergence Disorder
☐ TBI
☐ Oculomotor Dysfunction
☐ Other Binocular Dysfunction

Special Population Exam

☐ InfantSEE
☐ Special Needs
☐ Impaired communication

Visual Information Processing Assessment

☐ History of Dyslexia or IEP
☐ General reading difficulty
☐ Other school difficulty_____

☐ **Myopia Control**

☐ **PEDIG Study**

☐ **Vision Therapy**

Referral to Include:

☐ **Evaluate and consult** ☐ **Evaluate, treat, return for primary care** ☐ **Assume responsibility of care**

Refer To:

☐ **First Available**
☐ Dr. Emily Aslakson
☐ Dr. Sara Bush
☐ Dr. Alison Jenerou
☐ Dr. Paula McDowell
☐ Dr. Avesh Raghunandan
☐ Dr. Mark Swan
☐ Dr. Dan Wrubel
☐ Pediatric and Binocular Vision Resident
☐ Other _____

Please fax last comprehensive exam and any additional information, comments, or concerns to (231) 591- 3991, **Attn: Kerrie Currie**

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