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
☐ Accommodative Disorder
☐ Vergence Disorder
☐ Oculomotor Dysfunction
☐ Other Binocular Dysfunction

Special Population Exam

☐ InfantSEE
☐ Special Needs
☐ Impaired communication

☐ **Vision Therapy**

Visual Information Processing Assessment

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

☐ **PEDIG Study**

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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