ENDEAVOR EYE CENTER

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Please FAX this form to 253-759-0785 or
EMAIL it to contact@endeavoreye.com
Please provide a copy of the patient's most recent office visit, if possible.

Patient name: _____DOB: _____

Patient Phone: _____ Insurance: _____

Referral Type:

[ ] Pediatric exam (birth+)
[ ] Strabismus
[ ] Amblyopia
[ ] Vision related learning difficulties
[ ] Other:

[ ] Binocular Vision Evaluation
[ ] Post concussion- TBI
[ ] Hemianopsia – post stroke
[ ] Diplopia- Prism

Pertinent findings:

Refraction OD_____VA_____

OS_____VA_____

Clinical findings: _____ DFE: Yes No

_____

Referring Doctor: _____

Office Phone:_____Fax:_____

Email:_____