Vision Forward Association

Growing Through Vision Loss

Referral for Vision Consultation

Child's Name: _____ Date of Birth: _____ Gender: ☐Male ☐Female

Parent's Name: _____

Legal Guardian's Name (if applicable):_____

Child's Address: _____

Phone Numbers: (Home) _____ (Cell) _____

Parent Email:_____

SSN: _____-_____-_____ or Medicaid ID: _____

Latino Origin (Y/N) _____ Race _____

Pediatrician: _____Phone:_____

Ophthalmologist: _____Phone: _____

Date Ophthalmologist last seen: _____

Other Specialists: _____

_____

Current Services: ☐Occupational Therapy ☐Physical Therapy ☐Speech & Language ☐Vision Services

☐Early Childhood Education ☐Hearing Services ☐None ☐Other: _____

Name of Current Service Provider: _____Place of Current Services: _____

Summarize Child's Current Development Level: _____

_____

_____

Summarize Vision Concerns/Diagnosis: _____

_____

_____

Other pertinent medical information including allergies, precautions, birth history: _____

_____

_____

Describe relevant family information:_____

_____

_____

Person Making Referral: _____ Agency name: _____

Referral Address: _____Email:_____

Referral Phone: _____ Referral Date:_____

PLEASE SEND COMPLETED REFERRAL FORM TO:

VISION FORWARD ASSOCIATION
912 NORTH HAWELY ROAD
MILWAUKEE, WI 53213
FAX (414)238-2261