Lynn A. Sulerud, OD
Georgiann Jensen, OD
Ryan Fedor, OD
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BlaineEye CLINIC

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763-757-7000 | Phone
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REFERRAL FORM

Fax to 763-757-3328 or Email to referrals@blaineeyeclinic.com
Please also send records of most recent medical eye exam along with this form.

Date

Referred By

Address

City State Zip

Phone Fax

Patient's Name Age Date of Birth

Contact Information: Parent's Name

Address

City State Zip

Home Phone Cell Phone

Insurance Information (if known): Carrier (BCBS, Medica, etc): _____

ID # _____ Group #_____

(If easier, please include a copy of the patient's medical insurance card)

Reason(s) for Referral:

- ☐ Binocular Vision Disorder
- ☐ Accommodative Difficulties
- ☐ Strabismus/Amblyopia
- ☐ Visual Perceptual Problems
- ☐ Problems with Attention
- ☐ Other:_____
- ☐ Eyestrain/Headaches
- ☐ Diplopia
- ☐ Convergence Insufficiency / Excess
- ☐ Poor Handwriting
- ☐ Developmental Delays
- ☐ Post Trauma/Stroke Vision Evaluation
- ☐ Tracking/Oculomotor Dysfunction
- ☐ Loss of Place when Reading
- ☐ Trouble Copying from Board
- ☐ Difficulty seeing 3D/Stereo Vision

Results of Examination:

Refraction: ☐ Wet ☐ Dry

OD_____ VA OD_____ Spec Rx OD_____

OS_____ VA OS_____ Spec Rx OS_____

(if given)

☐ DFE performed – no ocular health abnormalities noted Other: _____

Additional information: _____

_____

_____

A copy of a report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.