HAZEL EYE CENTER

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West Warwick, RI 02893

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Pediatric Referral Form

Date of Referral	
Referring Provider	
Patient Name	
Patient Date of Birth	
Parent/Guardian Name	
Parent/Guardian Phone	
Patient Medical Insurance	
Patient Vision Insurance	
Referring For:	☐ **Binocular Vision Evaluation/Vision Therapy***
	☐ **Strabismus/Amblyopia Evaluation***
	☐ **Myopia Management****
	☐ **Pediatric Comprehensive Examination**

*Please send a copy of the most recent comprehensive exam **with cyclo** when referring for Binocular Vision Evaluation or Strabismus/Amblyopia Evaluation. If this is not possible, we will perform a cyclo at our first visit and schedule a follow-up Binocular Vision Evaluation or Strabismus/Amblyopia Evaluation.
**For Myopia Management, we use MiSight, MF toric CLs, and/or custom atropine dosing to best fit the patient's needs. For patients and parents interested in Ortho-K specifically, please contact us for recommendations.