Vision Development Center

Guiding Vision Beyond 20/20

FAX: Referral

The following information is private due to it containing personal information regarding patients of this office. Please refer to the HIPPA regulations for specifics of sharing patient information.

To:	**Dr. Joan Bauernfiend**	**From:**	
Date:		**Pages:**	
Fax:	**812-482-1422**	**Phone:**	**812-482-1411**
Re:			

Referral Information:

Patient Name:_____Date of Birth:_____

Parent/Guardian Name:_____

Home Phone:_____Alternate Phone:_____

Address:_____

City/State/Zip:_____

Reason for Referral:

- ☐ Strabismus
- ☐ Amblyopia
- ☐ Vergence/Accommodative Disorder
- ☐ Tracking Abnormalities
- ☐ Learning Related Difficulties
- ☐ Traumatic Brain Injury Rehabilitation
- ☐ Other:_____