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Patient Referral Request

Thank you for referring your patient to Dr. Elizabeth A. Bower, O.D for a binocular evaluation. Please help us facilitate the scheduling process by providing us with some information about your patient.

*****We will contact the patient to schedule within 1-3 days after reviewing this referral information*****

Name of referring doctor: _____

Office phone: _____ FAX: _____

Patient name: _____

Patient phone: _____

Patient vision insurance: _____ Policy number: _____

Patient medical insurance: _____ Policy number: _____

Specific reason(s) for referral/problems to be addressed:

Amblyopia
Insufficiency

Accommodative Dysfunction

Convergence

Convergence Excess

Double Vision

Difficulties with school/reading

*Details: _____

*****Please attach a copy of the patient's most recent exam*****

Please fax any other relevant information that will help us care for your patient. Thank you for allowing Dr. Elizabeth Bower to participate in your patient's care. A summary report will be sent to you.