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Easily refer your patient to us for a Neurovisual BVD evaluation:

Step 1: Copy this form, then enter pt info, check the symptoms, & safely fax to 253-514-6719 or email info@eyecandy-optical.com.

Date _____ Referred by _____
Patient _____
Cell # _____ Pt Email _____

- | | |
|---|--|
| <input type="checkbox"/> Headache / Migraine | <input type="checkbox"/> Reading / Learning issues |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea / Motion sickness |
| <input type="checkbox"/> Neck Pain / Head Tilt | <input type="checkbox"/> Sound sensitivity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Gait instability | <input type="checkbox"/> Double / Blurred / "Off" vision |
| <input type="checkbox"/> Post-concussion or TBI | <input type="checkbox"/> Other _____ |

Step 2: That's it. We will email them the forms. We are always here if you have questions.