Other Health Care Providers and Therapists

Gabrielle Family Vision Care 11411 NE 124th St., Bldg A, Ste 118 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2006
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Patient Name (LAST, First):_____ **Patient DOB (Month/Day/Year):**_____

Many of our patients see other providers & therapists to work on specific areas of challenge in their overall treatment plan. To allow for the best co-management and to keep them informed of your vision health, we can communicate and coordinate with your health care providers. Our goal is to provide the highest quality of care and we have found that close communication with other providers has helped our patients tremendously, i.e. helping an OT or PT to know the importance to use your glasses during your session, letting your PCP know your vision health updates. Please list the names & office locations of your other providers below.

❑ Referring Optometrist **❑ Referring Provider**

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary (and Chart Notes if applicable)

Name
Clinic
Address
City
State
Zip Phone #

❑ Occupational Therapist

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary

Name
Clinic
Address
City
State
Zip Phone #

❑ Primary Care Physician **❑ Naturopath**

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary

Name
Clinic
Address
City
State
Zip Phone #

❑ Cranial Sacral Therapist **❑ Physical Therapist**
❑ Chiropractor

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary

Name
Clinic
Address
City
State
Zip Phone #

❑ Speech Language Pathologist
❑ Audiologist

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary

Name
Clinic
Address
City
State
Zip Phone #

❑ Educational Providers (teacher, school, tutor)
❑ Other_____
❑ Counselor **❑ Psychologist**

We may communicate with your provider via:

❑Email ❑Call/Speak in Person ❑Mail/Fax Assessment and Plan Summary

Name
Clinic
Address
City
State
Zip Phone #

❑ I DECLINE COMMUNICATION WITH OTHER PROVDERS/INDIVIDUALS AND DECLINE THE MAILED SUMMARY

*We type a complimentary mailed summary for new patient exams, for patients before starting vsion therapy and for patients after graduating vision therapy. Established patients can request a mailed summary for a fee.

By signing this form, I acknowledge that the above information is true and correct to the best of my knowledge. I also acknowledge that Gabrielle Family Vision Care will be communicating health information to the above providers. This agreement will remain in effect until I give written notice of any changes.

Signature of Patient or Responsible Party	Print Name of Patient or Responsible Party	Date (M/D/Yr)	Staff Initials	Date (M/D/Yr)