



Community and Public Health
Environmental Initiative

Vision Referral Form Primary Care Provider

Date of Referral: _____

Dear Parent/Guardian of Child's Name _____ Date of Birth _____:

As you know, all children participating in our program receive a vision screening. We are pleased to offer this as a helpful resource in caring for your child's vision health.

The results of your child's vision screening are attached to this letter.

At this time, we are referring your child to his/her primary care provider for a follow-up exam. Please make an appointment as soon as possible. If you have questions or concerns, please call us at 410-706-2784 or 410-706-2812.

Let us know if you need any help in making this follow-up appointment. If you need any help with a referral to an ophthalmologist, please contact us at one of the phone numbers listed above or by e-mail.

Sincerely,

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