Florida's Vision Quest (FVQ)
2018-2019 Guidelines for Vision Referrals

Students Must Meet All Three Criteria:

- **Enrolled in public schools (PreK-12),**
- **Failed** a school-based vision screening at 20/40 or worse **and,**
- **Not have access** to Medicaid, Medicaid HMOs, other government sponsored health insurance, or commercial insurance that cover eye exams and glasses

Submitting a Referral:

- Fill out **left-hand side** of the FVQ Referral Form **COMPLETELY.** Print or type information only.
- Must provide School District assigned **Student ID#.**
- **Fax** - 386-917-1008 or 386-917-1009, or
- **Email** – scan completed form into a computer and email to **Becky@flvq.org**.
- **Mail** - Florida's Vision Quest, 167 N. Industrial Dr., Orange City FL 32763

What happens next?

After FVQ receives the referral and **eligibility is verified**, a **letter will be sent to the family** with the assigned Doctor's information and instructions.
Letters will be in **both English and Spanish**.
Parent/Guardian **must schedule an appointment** with the **assigned Doctor** upon receiving the letter.
After the examination, if glasses are required, **glasses will be mailed to the Doctor's office** for dispensing.

Important reminders:

- **Only school or health department staff may submit referral forms.** DO NOT GIVE TO FAMILIES!
- Referrals completed by students or families **will not be processed!**
- Please remember that this program is designed to provide eye exams and eyeglasses for students who **would not be able to obtain them by any other means** due to financial hardships.

Replacing Broken or Lost Eyeglasses:

- Eyeglasses have a **six-month warranty**. Call our office at 386-917-1001 x226 or x228 for information.

- **Additional** eyeglasses may be purchased for a fee of **$48.00**.

  - Please call our office at **386-917-1001 ext. 228** to purchase via **credit/debit card**.
    A **$2.00 processing fee** will be charged on all credit/debit card transactions.

  OR

  - If preferred, parents may **mail a check/money order** (**payable to Vision Quest Lab, LLC**) with a note that includes **child's name, date of birth**, a **daytime phone number**, and the **return mailing address** to:

Florida's Vision Quest
167 N. Industrial Drive
Orange City, FL 32763

PH: 386-917-1001 x228 or 221
FAX: 386-917-1008 or 386-917-1009

Florida's Vision Quest
Referral Form

167 N. Industrial Drive
Orange City, FL 32763

Section I: Completed by school/health department personnel.

Date:________________ County: ______________________

Student ID#: ______________________________ (Must have to process)

Student Name:____
First M.I. Last

Date of Birth: ____/____/______ Gender: Male or Female

Parent/Guardian Name: ______________________________

Mailing Address: ___________________________________

City: __________________________ FL Zip: __________________

Phone#: ___________________________

Email : ______________________________________

Send Spanish letter? ☐ Does child wear glasses? ☐

Does child have access to vision insurance? Y or N

Did child fail vision screening, per State guidelines? Y or N

Vision Screening Date ___/___/___

Ethnicity/Race:

- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White
- ☐ Other

School : ____ ES MS HS

Grade: _______

Eligibility Verified By:

____

Referral Contact Signature and Title

Contact Name: ________________________________

Contact Phone: (______) _____-____________ ext. _______

Contact Fax: (______) ______-____________

Contact E-Mail: ____

Section II: Completed by Physician and Optical

Student Name: ____

Parent/Guardian Signature for Permission on File? _______ (Please initial)

Dr. _________________________________ County:___________________

In Office ____ On Mobile Unit ____

Dr. Ph: (______)_______-_________ Dr. Fax: (______)_______-_________

Diagnosis (circle all that apply) Exam date: _________________

Amblyopia	Esotropia	Hyperopia
Astigmatism	Emmetropia	Myopia
Color Blind	Glaucoma	Strabismus

Other:__________________________

Best corrected acuity:

R 20/______

L 20/______

	Sphere	Cyl	Axis	Prism	Direction	Base Curve	Lens type
R							SV
L							FT
	Add	Seg Ht	OC Ht	PD			TRI
R				DISTANCE			OTHER
L				NEAR			

FRAME	Color	Eye Size	DBL	All Frames Supplied By Lab

Dilation: Yes ___ No ____ If 'No', why?

____

____

Send To:

Notes:

Insurance (FLVQ Ofc. Only) Eligible(No Ins.)____ Ineligible ______________

Dispensed Date:

Revised 6/18