Submit by Email | Print Form

Vision Therapy Assessment Referral

Today's Date _____

Referring Healthcare Provider

Name: _____

Telephone: _____

Fax: _____

Email: _____

_____
Patient Name

_____
DOB

_____
OHIP Number

_____
Address

_____
City Postal Code

_____
Telephone Number

REASON FOR REFERRAL:

- ☐ Perceptual Evaluation
- ☐ Eye Tracking/Oculomotor
- ☐ Strabismus
- ☐ Accommodative Dysfunction
- ☐ Amblyopia
- ☐ Traumatic Brain Injury
- ☐ Binocular Dysfunction
- ☐ Concussion

Refraction & BCVA:

OD_____ (20/__) OS_____ (20/__)

Comments/ Relevant Examination Results:

_____
_____
_____
_____

Or Fax this form to 289-769-0494
Our office will contact the patient to book an appointment