Dr. Shirley Ha
Neuro-Developmental Optometrist
482 South Service Road E, Suite 115, Oakville, ON L6J 2X6
Tel: 905-582-4800; **Fax: 289-715-2538**
Email: info@ahavision.ca

Referring professional:

Doctor Name:

Clinic name:

Phone:

E-mail:

Patient:

Full Name: ______________________________ DOB: ____________ Cell No: ____________________

E-mail: ______________________________@__________ Health Card: ________________________

Reason for referral (Check all that apply):

__ Eye Tracking/Oculomotor
__ Accommodative Dysfunction
__ Binocular Dysfunction
__ Visual-Motor Problems
__ Learning Related Vision Issues
__ Perceptual Evaluation
__ Strabismus
__ Amblyopia
__ Concussion
__ ABI/TBI
__ Sports Vision Training
__ Special Populations (CP/Downs, Autism etc)

__ Other – Please describe:____

Refraction: OD______________________ 20/__ OS_______________________ 20/__
Ocular Health: __ Within Normal Limits Other:_________________________

Comments/Other relevant examination findings:____

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Please email or fax this form. Our office will contact the patient directly to book appointment.

Thank you for your referral.