KW NEUROVISION
MAXIMIZING YOUR VISION POTENTIAL

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BINOCULAR VISION EVALUATION FAX REFERRAL FORM - FAX TO: 519-745-0506

Date

Referred By

Address

City Province Postal Code

Area Code Phone Best time to call

Patient's Name Age Date of Birth

Contact Information: Parent's Name

Address

City Province Postal Code

Area Code Phone Best time to call

Reason(s) for Referral:

- ☐ Binocular Vision Disorder
- ☐ Accommodative Difficulties
- ☐ Strabismus/Amblyopia
- ☐ Visual Perceptual Problems
- ☐ Problems with Attention
- ☐ History of Concussion
- ☐ Eyestrain/Headaches
- ☐ Diplopia
- ☐ Convergence Insufficiency / Excess
- ☐ Poor Handwriting
- ☐ Developmental Delays
- ☐ Other:_____
- ☐ Neuro-Optometric Vision Evaluation
- ☐ Tracking/Oculomotor Dysfunction
- ☐ Difficulty with Reading
- ☐ Trouble Copying from Board
- ☐ Difficulty seeing 3D/Stereo Vision

Indicate results of most recent examination or Print and Fax a Copy of the exam (if possible):

Refraction: ☐ Wet ☐ Dry

OD_____ VA _____ Current Spec Rx _____

OS_____ VA _____ Current Spec Rx _____

☐ no ocular health abnormalities noted (DFE performed___) Other: _____

Additional information:

ATTENTION PATIENT & REFERRING DOCTOR – PLEASE READ PARAGRAPH BELOW AND SIGN ON THE LINE:

I hereby grant permission for Dr. K. Dolman and any other professional involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I also hereby give permission to have this information faxed to Dr. K. Dolman so that her office can contact me (or my appointed representative) to schedule an evaluation.

Patient/Parent Signature Date Signature (Doctor) Date

A report will be sent to the referring doctor.
Patients will return to referring doctor's office for all primary eye care and eyeglass prescriptions.