Visual Therapy Assessment Referral

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Calgary Vision Therapy
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PATIENT NAME: Mr /Mst / Mrs / Miss / Ms

DOB: AHC#: Parents Name:

PHONE #: ADDRESS:

EMAIL: Postal Code:

REASON FOR REFERRAL:

□ Learning Difficulty □ Visual Perceptual Testing □ Amblyopia □ Strabismus

□ Convergence Insufficiency □ Binocular Coordination/Accommodative Dysfunction

□ Other: _____

Comments/History:

Any previous eye surgeries? Yes / No _____

Medications: Refraction: OD VA 20/

OS VA 20/

Were glasses prescribed? Yes / No Are glasses currently being used? Yes / No

Ocular Health: EOM'S: Any EOM restrictions/palsy/paresis? Yes / No

Binocular Vision Test results: Accommodation Test results:

Any previous visual training or treatment (ie. patching etc?)

Referring Optometrist: _____

Referring office fax #: _____ Referring email address: _____