Patient Referral Form

If you have a patient that needs one of our listed services, please fill out the form. If you prefer, download and complete the form, and email it to info@mountjoyeyecare.com.
Our office will contact the patient directly to book the appointment and we will send your office an email once the appointment is booked.
Our listed services are not insured by OHIP, fees will be advised to patients.
If you have any questions or concerns, you can contact our therapy coordinator at info@mountjoyeyecare.com.

Name (Referring health care provider) *

First Name

Last Name

Address (Referring office) *

Clinic's Name or Legal Office

Street Address

City

Province

Postal Code

Country

Phone Number (Referring office) *

Please enter a valid phone number.

Fax Number (Referring office)

Please enter a valid fax number.

Email

example@example.com

Patient's Personal Information

Name *

First Name Last Name

Phone Number *

Please enter a valid phone number.

Email

example@example.com

Name of parent/guardian (if applicable)

First Name Last Name

Reason for referral (choose all that apply)

Preferred Service(s): *

- ☐ Functional Vision Exam (eg. assessment for vision therapy or myopia management)
- ☐ Myopia Management Assessment
- ☐ Vision Therapy Assessment
- ☐ Syntonics Assessment (Ocular Phototherapy)
- ☐ Dry Eye Exam

Reason(s) for referral (choose all that apply): *

- ☐ Car accident/Concussion
- ☐ Autism Spectrum Disorder
- ☐ Tracking Problems
- ☐ Vestibular Problems
- ☐ Amblyopia/Lazy Eye
- ☐ Letter Reversals

- [ ] Learning Problem
- [ ] Visual Discomfort/Headaches
- [ ] Attention Problems, ADD/ADHD
- [ ] Eye-Hand Coordination Problems
- [ ] Post-Trauma/Stroke Vision Evaluation
- [ ] Visual Perceptual Problems
- [ ] Dryness/Grittiness
- [ ] Soreness/Irritation
- [ ] Burning/Strining
- [ ] Watering
- [ ] Eye Fatigue
- [ ] None/Other

Current/Previous Assessment (choose all that apply):

- [ ] Occupational Therapy
- [ ] Primitive Reflexes Evaluation
- [ ] Chiropractor
- [ ] Physiotherapy
- [ ] Auditory Processing Assessment
- [ ] Neuro-Education Assessment
- [ ] Other

Current/Habitual Eyeglasses Rx:

eg. OD -4.00 -0.50 x 180 OS -6.00 -1.00 x 180

Manifest Refraction (include date):

eg. OD -4.00 -0.50 x180

Best Corrected Visual Acuity at Distance:

eg. OD 20/50, OS 20/30

Comments/Relevant Examination Results: