ORANGEVILLE VISION DEVELOPMENT CENTRE

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PATIENT REFERRAL FORM - HEALTH PRACTITIONERS

Referring Practitioner

Name: _____

Phone #: _____ Fax #: _____

Date of Exam: _____

Patient Information

Name: _____

Address: _____

Email Address: _____

Phone #: _____Cell #: _____

Date of Birth: Month: _____ Day: _____Year: _____

Please use this form to rule out visual related conditions which may be contributing to, or as a result of any of the following conditions :

Reason for Referral

☐ Strabismus(eye turn)
☐ Learning Problems
☐ Lack of depth perception
☐ Sports performance enhancement
☐ Post Brain Injury/Concussion
☐ Frontal headaches
☐ Oculomotor Dysfunction
☐ Double vision
☐ Amblyopia (lazy eye)
☐ Stroke
☐ Other

Please inform your patient that assessments and therapy sessions are not covered by OHIP. Our office cannot determine if your patient has coverage through their extended health insurance. We recommend the patient contact their personal insurance provider to inquire if coverage if reserved for 'Vision Training' and assessments. We could provide them a letter for insurance purposes to see if they qualify for funding.
We are not able to submit directly to insurance companies for visual assessments and training. We can provide patients with the invoice receipts for submission/reimbursement.

If your patient sustained injuries due to a motor vehicle accident, and currently has a claim open with their auto insurance company, we can submit an OCF-18 through HCAI for funding.

Thank you for allowing OVDC to share in your patient's vision care. A report will be sent to your office at the completion of services.