



PATIENT REFERRAL FORM – OPTOMETRIST

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Strabismus(eye turn) | <input type="checkbox"/> Post Brain Injury/Concussion | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Frontal headaches | <input type="checkbox"/> Amblyopia (lazy eye) |
| <input type="checkbox"/> Lack of Stereopsis | <input type="checkbox"/> Oculomotor Dysfunction | <input type="checkbox"/> Post stroke vision |
| rehabilitation | | |
| <input type="checkbox"/> Sports performance enhancement | | <input type="checkbox"/> Other |

Present Rx:

OD: _____ 20 / _____

OS: _____ 20 / _____

Ocular Health: _____

Visual Fields have been completed on the patient: YES / NO Any defects? YES / NO

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 is reserved for 'Vision Training' and assessments. 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.