



ABI / CONCUSSION / STROKE RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ Male Female
Date of Birth: _____ (M/D/Y) Age: _____ Occupation: _____
Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: 1) _____ 2) _____
Email: _____ Referred by: _____
Health Card #: _____ Version Code: _____
Last eye exam: _____ Date of Loss/Accident/Stroke: _____
Optometrist's Name: _____ Optometry Clinic Name: _____
Phone Number: _____ Fax _____
Number: _____

INSURANCE INFORMATION

Are your impairments due to a stroke? Yes No

Are your impairments due to an accident at work? Yes No

Are you currently on **WSIB**? Yes No

If YES, Do you want us to submit a WSIB claim for funding? Yes No

If YES, please provide us your WSIB claim information:

Authorizing Nurse Name: _____ Authorization Number: _____
Phone Number: _____ Fax Number: _____
Claim Number: _____ Other Info: _____

Are your impairments due to a sport related accident? Yes No

Are your impairments due to an MVA? Yes No

If YES, is your case settled? Yes No

Do you want us to submit an **OCF-18** to your **auto insurance** for funding? Yes No

If YES, please provide us your **insurance** information:

Are you the primary policy holder? Yes No

If NO, please provide us the information of the primary policy holder:

Name: _____ Relationship: _____ Phone Number: _____

Auto-Insurance Company Name: _____

Address: _____

Phone Number: _____ Ext: _____ Fax Number: _____

Adjuster's Name: _____ Email: _____

Claim Number: _____

Name of your **Case manager/ OT:** _____ Phone Number: _____

Email: _____ Fax Number: _____

Other Insurance (Employer, Private etc.): Policy Holder's Name: _____

Company Name: _____

Policy Number: _____ Member ID: _____

Amount of Coverage towards optometric care (ie. glasses, exam, vision therapy) _____

Spouse's Insurance Information (If applicable): Policy Holder's Name: _____

Company Name: _____

Policy Number: _____ Member ID: _____

Amount of Coverage towards optometric care (ie. glasses, exam, vision therapy) _____

HEALTH HISTORY

Briefly state the visual concerns that you are experiencing: _____

Family Doctor: _____ Clinic Name: _____

Family Doctor's Phone Number: _____ Fax Number: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Do you have any of the following:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colour Blindness |

Have you experienced any of the following?

- | | | | |
|---|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Whiplash | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Cranial Sacral Therapy |
| <input type="checkbox"/> Closed head injury | <input type="checkbox"/> Unconscious | <input type="checkbox"/> MRI | <input type="checkbox"/> Chiropractic Therapy |
| <input type="checkbox"/> Physiotherapy | | | |

Do you get anxious and overwhelmed in the following situations?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Large groups and crowds | <input type="checkbox"/> Driving | <input type="checkbox"/> Big box stores |
| <input type="checkbox"/> Public Transit | <input type="checkbox"/> Loud noises | |

Do you currently have a valid driver's license? Yes No

Has your driver's license ever been suspended? Yes No

Are you currently working (full time or part time)? Yes No

Do you currently experience any of the following?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Eye turn |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Eye Pain/Strain |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Flashes |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Rubbing eyes | |
| <input type="checkbox"/> Squinting | |

What are the frequency and severity of your headaches

Do you experience any of the following when reading?

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Print moves/jumps around | <input type="checkbox"/> Lose place | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Hold reading material close | <input type="checkbox"/> Skip or re-read lines | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor comprehension | <input type="checkbox"/> Reading makes you tired | <input type="checkbox"/> Blur |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Shut one eye while reading | <input type="checkbox"/> Headaches |

Do you currently have difficulties in the following areas?

- | | |
|---|---|
| <input type="checkbox"/> Hand writing | <input type="checkbox"/> Trip over objects/curbs |
| <input type="checkbox"/> Reverse letters or words | <input type="checkbox"/> Lose balance while walking |
| <input type="checkbox"/> Printing/handwriting | <input type="checkbox"/> Feel dizzy |
| <input type="checkbox"/> Catching a ball | <input type="checkbox"/> Feel nauseous |
| <input type="checkbox"/> Bump into things/people | <input type="checkbox"/> Poor Comprehension |
| <input type="checkbox"/> Judging distances | <input type="checkbox"/> Poor memory/forgetful |

Do you experience light sensitivity indoors? Yes No

Are you sensitive to sunlight? Yes No

Does light induce headaches? Yes No

Brief description of how the accident occurred: _____

Explain in short sentence your daily life routine and goals:

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I DO NOT GIVE ORANGEVILLE VISION DEVELOPMENT CENTRE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS

Signature

Date