33A First Street
Orangeville, Ontario
L9W 2C8
Tel: 519-940-8426
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www.OVDC.ca

PATIENT REFERRAL FORM – FROM EDUCATIONAL PROFESSIONALS

Referring Professional (please circle one):

| OT | Teacher | Tutor | Other:________________________________

Name: ____

Phone #: ____ Fax #: ____

Date of referral: _____________________________________ Email: ____

Patient Information

Name: ____

Address: ____

Email Address: ____

Phone #: ____ Cell #: _______________________________________

Date of Birth: Month: _________________ Day: __ _____ Year: _____ __ Age: ________

Guardian name(s) if a minor: ____

Reason for Referral

- ☐ Skips lines or re-reads lines
- ☐ Slow completion of work
- ☐ Poor coordination
- ☐ Well behind in reading level
- ☐ Poor reading comprehension
- ☐ Reverses letters like ‘b’ & ‘d’
- ☐ Headaches & eye strain
- ☐ Forgetful/poor memory
- ☐ Poor handwriting
- ☐ Short attention with reading type tasks
- ☐ Rubs eyes
- ☐ Poor confidence with learning

Additional Comments:

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Please inform your student/parent that assessments and therapy sessions are not covered by OHIP. Our office cannot determine if your student/parent has coverage through their extended health insurance. We recommend the parent 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 parents with the invoice receipts for submission/reimbursement.

Thank you for allowing OVDC to share in your student’s vision care. A report will be generated at the completion of services.