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InDepth Vision
VISION THERAPY AND REHABILITATION

Vision Therapy Assessment Referral

Today's Date: _____ Patient Name: _____

Referring Professional: _____ D.O.B: _____

Tel: _____ Address: _____

Fax: _____ _____

_____

Tel: _____

REASON FOR REFERRAL: (Please check all that apply)

- ☐ Strabismus
- ☐ Amblyopia
- ☐ Difficulty at school
- ☐ Reading concerns
- ☐ Other: _____
- ☐ Eye Tracking/Oculomotor
- ☐ Accommodative Dysfunction
- ☐ Binocular Dysfunction
- ☐ Difficulty at School
- ☐ Perceptual Evaluation
- ☐ Concussion
- ☐ TBI / ABI
- ☐ Sports Vision Evaluation

Refraction OD: _____ 20/____ Refraction OS: _____ 20/_____

COMMENTS/RELEVANT EXAMINATION RESULTS: _____

Please Fax this form to 905-875-5468

Our office will contact the patient to book an appointment

Once the patient has completed their assessment a copy of their report will be faxed to your office