EYESONSHEPPARD
OPTOMETRISTS

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VISION IN MOTION

Neuro Visual Training Centre

If you have a client or a patient that needs a Binocular Vision Assessment done, please fill out the following form. Our office will contact the patient directly to book the appointment and we will send your office an email once the appointment is booked.

If you have any questions or concerns, you can contact our department at visiontherapy@eyesonsheppard.com

1. Please enter referral source's information. (this is your office's information)

First Name: _____ Last Name: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Email: _____ Clinic/s Name or Legal Office _____

2. Please enter your client/patient's personal information

First Name _____ Last Name _____

Email address _____ Mobile Phone _____

Date of Birth _____ Name of parent/guardian (if applicable) _____

3. Reason for referral (choose all that apply):

- ☐ Car accident/Concussion
- ☐ Amblyopia/Lazy Eye
- ☐ Attention Problems, ADD/ADH
- ☐ Autism Spectrum Disorder
- ☐ Letter Reversals
- ☐ Eye-Hand Coordination Problems
- ☐ Vestibular problems
- ☐ Learning Problem
- ☐ Post Trauma/Stroke Vision Evaluation
- ☐ Tracking Problems
- ☐ Visual Discomfort/Headaches
- ☐ Visual Perceptual Problems
- ☐ Other

4. Current or previous assessments (choose all that apply):

- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Neuro-Educational Assessment
- ☐ Primitive Reflexes Evaluation
- ☐ Auditory Processing Assessment
- ☐ Sports Medicine
- ☐ Chiropractor
- ☐ Other

I hereby grant permission for Dr. Adriana Cotovio and any other practitioner involved in my care to exchange information concerning my case, history, results of examination, diagnoses, treatment, etc. I hereby give permission to have this information faxed to Dr. Cotovio so that her office can contact me (or an appointed representative) to schedule an evaluation.

_____ _____

Signature Date