INSPIRE
VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

ABI / CONCUSSION / STROKE RELATED VISION PROBLEMS

PATIENT INFORMATION

Name: _____ Male / Female

Date of Birth: _____ (M/D/Y) Age: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Referred by: _____

Health Card #: _____ Version Code: _____

Last eye exam: _____ Date of Accident/Stroke: _____

Emergency Contact:_____ Relationship:_____ Phone Number:_____

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

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 with your auto insurance information:

Insurance Company Name: _____

Address: _____

Phone/Fax Number: _____

Adjuster's Name: _____

Claim Number: _____

Other Insurance (Employer, Private etc.):

Company Name: _____

Policy Number: _____ Member ID: _____

Coverage for Optometric Care Due to MVA (ie. glasses/ vision therapy):_____

Name of your case manager or OT: _____

HEALTH HISTORY

Briefly state the visual concerns that you are experiencing: _____

_____

Family Doctor: _____ Phone Number: _____

Past surgical history: _____

Medications: _____

Allergies: _____

Do you have any of the following:

□Glaucoma	□Diabetes	□Thyroid
□Cataracts	□Stroke	□High Blood Pressure
□Retinal Detachment	□Asthma	□Colour Blindness
□Macular Degeneration	□Arthritis	□Heart Problems

Have you experienced any of the following?

□Eye Injury	□Unconscious	□CT Scan
□Closed head injury	□Physiotherapy	□MRI
□Whiplash	Chiropractic Therapy	□Cranial Sacral Therapy

Do you get anxious and overwhelmed in the following situations?

□Large groups and crowds □Driving □Big box stores
□Public Transit □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?

□Burning eyes
□Watery eyes
□Dry eyes
□Itchy eyes
□Rubbing eyes
□Squinting
□Eye turn
□Eye Pain/Strain
□Flashes
□Headaches

What are the frequency and severity of your headaches
_____
_____

Do you experience any of the following when reading?

□Print moves/jumps around	□Lose place	□Blur
□Hold reading material close	□Skip or re-read lines	□Dizziness
□Poor comprehension	□Reading makes you tired	□Headaches
□Double Vision	□Shut one eye while reading	□Nausea

Do you currently have difficulties in the following areas?

□Hand writing	□Trip over objects/curbs	□Bump into things/people
□Reverse letters or words	□Lose balance while walking	□Judging distances
□Printing/hand writing	□Feel dizzy	□Poor Comprehension
□Catching a ball	□Feel nauseous	□Poor memory/forgetful

Do you experience light sensitivity indoors? Yes No
Are you sensitive to sunlight? Yes No
Does light induce headaches? Yes No

Additional comments or questions:

_____

_____

_____

⬜ **I GIVE** ORANGEVILLE VISION DEVELOPMENT CENTRE TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION & PERSONAL COMMUNICATIONS

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

_____ _____

Signature Date

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