ORANGEVILLE VISION DEVELOPMENT CENTRE
DR. PATEL & ASSOCIATES

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# ABI / CONCUSSION / STROKE RELATED VISION PROBLEMS

## PATIENT INFORMATION

Name: _____ ☐ Male ☐ Female ☐ Other _____

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 _____

## 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: _____

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

Email:_____ Fax Number: _____

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**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) _____

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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:**

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

**Have you experienced any of the following?**

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

**Do you get anxious and overwhelmed in the following situations?**

- ⬜ Large groups and crowds
- ⬜ Public Transit
- ⬜ Driving
- ⬜ Loud noises
- ⬜ Big box stores

**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
- ☐ Hold reading material close
- ☐ Poor comprehension
- ☐ Double Vision
- ☐ Lose place
- ☐ Skip or re-read lines
- ☐ Reading makes you tired
- ☐ Shut one eye while reading
- ☐ Nausea
- ☐ Dizziness
- ☐ Blur
- ☐ Headaches

**Do you currently have difficulties in the following areas?**

- ☐ Hand writing
- ☐ Reverse letters or words
- ☐ Printing/handwriting
- ☐ Catching a ball
- ☐ Bump into things/people
- ☐ Judging distances
- ☐ Trip over objects/curbs
- ☐ Lose balance while walking
- ☐ Feel dizzy
- ☐ Feel nauseous
- ☐ Poor Comprehension
- ☐ 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:**

_____

_____

_____

☐ **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