310 Broadway Avenue
Orangeville, ON
L9W 1L3
Tel: 519-940-8426
Fax: 519-341-1648
reception@OVDC.ca
www.OVDC.ca

PATIENT REFERRAL FORM – 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
☐ Poor reading comprehension
☐ Poor handwriting
☐ Slow completion of work
☐ Reverses letters like 'b' & 'd'
☐ Short attention with reading type tasks
☐ Poor coordination
☐ Headaches & eye strain
☐ Rubs eyes often
☐ Well behind in reading level
☐ Forgetful/poor memory
☐ Poor confidence with learning
☐ Blurry vision
☐ ____________________

Additional Comments:

____
____
____

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.