Dr. Palki Arora, OD FOVDR FAAO
Board-Certified Neuro-Optometrist
Vision Therapy and Rehabilitation
Suite 130 – 4000 Glenmore Court SE
(P) 403-242-1800 (F) 403-242-3833

Vision Therapy Assessment Referral

PATIENT NAME: Mr / Mst / Mrs / Miss / Ms _____

DOB: _____ Parents/Guardian Name: _____

AHC#: _____ PHONE#: _____

ADDRESS and Postal Code: _____

EMAIL ADDRESS: _____

REASON FOR REFERRAL:

☐ Learning Difficulty ☐ Visual Perceptual Testing ☐ Amblyopia ☐ Strabismus

☐ Convergence Insufficiency ☐ Binocular Coordination/Accommodative dysfunction

☐ MVA/Concussion ☐ Sports Vision Evaluation ☐ Other: _____

Comments/History:

Any previous eye surgeries? Yes / No

Medications: Refraction: OD VA 20/

OS VA 20/

Were glasses prescribed? Yes / No Are glasses currently being used by the patient? Yes / No

Ocular health: EOM's: Any EOM restrictions/palsy/paresis? Yes / No

Binocular Vision Test Results: Accommodation Test Results:

Any previous visual training or treatment (ie. patching etc?)

Referring Optometrist: _____

Referring office fax #: _____ Referring email address: _____