CM Optical Ltd.
Doctors of Optometry

Vision Therapy Clinic

615 Main Street, Suite 311
Yarmouth, NS B5A 1K1
(902) 742-1606 | cmoptical.ca

VISION THERAPY ASSESSMENT REFERRAL

Today's Date:_____

Referral from:

Tel:

Fax:

_____
Patient Name

_____
DOB

_____
Nova Scotia Health Card Number

_____
Address

_____
City Postal Code

_____
Telephone

CORRESPONDENCE: ☐ Fax Report ☐ Email Report

REASON FOR REFERRAL:

☐ Strabismus (eye turn)
☐ Amblyopia (lazy eye)
☐ Eye Tracking/Oculomotor
☐ Concussion/Brain Injury
☐ Accommodative/Eye focusing
☐ Visual Perceptual Evaluation
☐ Learning Difficulties
☐ Other: _____
_____

Refraction OD_____20/____ OS_____20/____

COMMENTS/RELEVANT HISTORY:

_____

_____

_____

_____

*Please Fax this form to (***902) 742-6969**,

Our office will contact the patient to book an appointment

Website: www.cmoptical.ca · Email: cmoptical@eastlink.ca