Thompson Optometry *est 1920*

Phone (905) 793-2020 Fax: (905) 793-8528 Email:vtadmin@thompsonoptometry.ca Web: www.thompsonoptometry.ca

Consultation Request Form

If you are a healthcare professional and would like to refer your patient to our clinic, **please complete the referral form below and email to vtadmin@thompsonoptometry.ca or print completed form and fax to (905) 793 – 8528.**

Please allow 48 business hours to process referrals.

Referring Professional: _____

Email:_____ Phone:_____ Fax:_____

Patient Name:_____

Health Card Number:_____ Date of Birth (y-m-d):_____

Address:_____

Email:_____ Phone:_____

Consult With (☐ Dr. Greg Thompson (JR) ☐ Dr. Rick Thompson (SR) ☐ No preference)			☐ Routine ☐ Vision Therapy	
Routine Eye Exam	Chief Complaint:			
Binocular Vision assessment	Strabismus	Amblyopia	Convergence insufficiency	Vertical Deviation
Vision Related learning Concerns	Losing place while reading	Poor reading comprehension/ retention	Poor printing	Letter reversals
Head Injury	Dizziness	Nausea	Light sensitivity	Double vision
Other				

	Right Eye	Left eye
Refraction		
BCVA	20/	20/

Additional Information:_____