



Referral for vision therapy/Neuro-optometric rehab

Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Patient information

Name: \_\_\_\_\_

DOfB: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Types of Service/Treatment Requested:

- Binocular Vision Exam (1.5 hour, may be separated to two visits.)**
- Strabismus/Amblyopia/covering one eye to read
- Attention Deficit
- Frustrations/stress after near work
- Falling asleep when reading/skipping lines when reading
- Car/motion sickness
- Concussion/neuro-optometric exam (1.5 to 2 hours, may be two visits.)**
- Trouble scanning across aisles when shopping
- Dizziness post concussion
- Double vision/eyes pulling post concussion
- Poor balance post concussion
- Light sensitivity post concussion
- Poor attention or poor memory post concussion

Patient History

Current diagnosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Sensitivities: \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

Please tear here and give to patients.

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Dr. Yan Ling Liang, Warden Optometry

101, 30 Gibson Dr. Markham ON

Ph 905-940-2015, Fax 905-940-1326

[wardenoptometry@gmail.com](mailto:wardenoptometry@gmail.com)

Your appointment with Dr. Yan Ling Liang is on: \_\_\_\_\_ (mth/day/year)

Please bring your glasses and list of medications to your visit.