KW NEUROVISION
MAXIMIZING YOUR VISION POTENTIAL

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Neuro-Vision Evaluation Referral Form

Date of Exam	Patient's Name Age Date of Birth
Referred By	Contact Information: Parent's Name
Address	Address
City Province Postal Code	City Province Postal Code
Phone Number	Patient's Phone Number Patient's Email

Reason(s) for Referral: _____

- ☐ Oculomotor Dysfunction
- ☐ Binocular Vision Dysfunction
- ☐ Convergence Insufficiency/Excess
- ☐ Strabismus/Amblyopia
- ☐ Accommodation Dysfunction
- ☐ Difficulty with Learning/School/Reading/Writing
- ☐ Visual Information Processing Difficulties
- ☐ Difficulty with Balance/Dizziness
- ☐ History of Concussion/Stroke/TBI Date:_____
- ☐ Other: _____

Please email or print and fax a copy of the most recent exam, or indicate results below:

Current Spec Rx: Dist VA

OD:_____

OS:_____

Latest Refraction: ☐ Wet ☐ Dry Dist VA

OD:_____

OS:_____

Oculomotor Notes: ☐ Normal ☐ Abnormal: _____

Binocular Vision Notes:
Cover Test Findings:
NPC:
Additional:

Ocular Health Notes: ☐ normal ☐ abnormal (describe below) DFE performed: ☐ Yes ☐ No

Additional Information:

_____
Doctor Signature Date

KW NeuroVision provides specialized neuro-optometric assessments and rehabilitation only.
Patients remain under the ongoing primary eye care of their referring optometrist, including for eyeglass prescriptions.
A detailed report will be sent to the referring optometrist following the evaluation.