



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 Phone consult (free 5-10 minutes consult by phone)**
- Binocular Vision Exam (incl visual information processing, 120 minutes + report)**
- Strabismus/Amblyopia/covering one eye to read
- Frustrations/stress after near work, attention deficit/ADHD symptoms
- Skipping lines when reading/Falling asleep when reading/
- Car/motion sickness
- Dizziness
- Double vision/eyes pulling
- Poor balance
- Light sensitivity
- Headaches
- Bothered by busy visual backgrounds
- Driving anxiety/poor driving confidence

Patient History

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

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

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

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

Please tear here and give to patients.

---

Dr. Yan Ling Liang, Warden Optometry

101, 30 Gibson Dr. Markham ON

Ph 905-940-2015, [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.