



Developmental Vision and Rehabilitation

ORDER FOR EVALUATION

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Referring Practitioner: _____
 Patient Name: _____
 Address: _____

 DOB: _____

Referring Location: _____
 Parent or Guardian: _____
 Cellular Phone: _____
 Home Phone: _____
 Email: _____

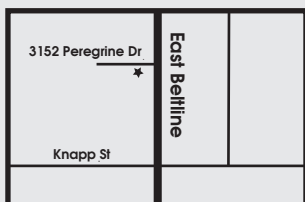
Diagnosis

- Post-Concussive Vision Syndrome
- Convergence Insufficiency
- Diplopia
- Oculomotor Dysfunction
- Accommodative Dysfunction
- Visual Field Loss
- Visual-Motor Dysfunction
- Developmental Delays
- Amblyopia
- Strabismus
- Autism
- ADD / ADHD

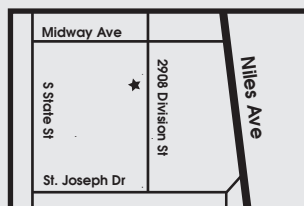
Symptoms

- Double Vision
- Transient Blur
- Headaches
- Motion Sickness
- Dizziness
- Vision Fatigue
- Letter Reversals
- Poor Concentration
- Slow Reading Speed
- Poor Reading Comprehension
- Poor Visual Memory
- Poor Visual Processing
- Poor Handwriting
- Poor Eye-Hand Coordination
- Light Sensitivity
- Visual Spatial Confusion

Additional Notes



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