ORDER FOR EVALUATION

Developmental Vision & Rehabilitation

Dan L. Fortenbacher, O.D., FCOVD
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Referring Practitioner: ______________________________
Patient Name: ______________________________
Address: ______________________________
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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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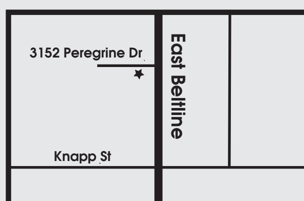

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