



ORDER FOR EVALUATION

Developmental Vision & Rehabilitation

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Patient Name: _____

Parent or Guardian: _____

DOB: _____ Gender: _____

Patient's Phone: _____

Patient's Email: _____

Referring Provider's Practice: _____

Address: _____

Referring Provider: _____

City: _____ State: _____ Zip: _____

Referring Provider's Email: _____

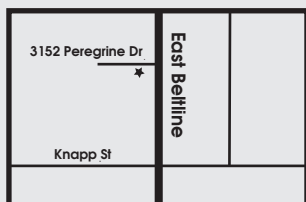
Diagnosis

- 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

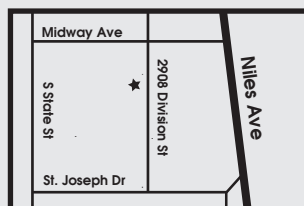
- Double Vision
- Transient Blur
- Headaches
- Motion Sickness
- Dizziness
- Vision Fatigue
- Letter Reversals
- Poor Concentration
- Slow Reading Speed
- Poor Reading Comprehension
- Poor Visual Memory
- Poor Visual Processing
- Poor Handwriting
- Poor Eye-Hand Coordination
- Light Sensitivity
- Visual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

Additional Notes



GRAND RAPIDS

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