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**REQUEST FOR ORTHOPTIC ASSESSMENT**

PATIENT: \_\_\_\_\_ DATE OF APPOINTMENT: \_\_\_\_\_  
(YYYY / MM / DD)

HEALTH CARD #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ Postal Code: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_  
(YYYY / MM / DD) HOME BUSINESS

REASON FOR REFERRAL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CYCLOPLEGIC REFRACTION**

O.D.

O.S.

**PRESENT R<sub>x</sub> AND VISUAL ACUITY**

O.D.

O.S.

OCULAR PATHOLOGY: \_\_\_\_\_

STRABISMUS / OCULAR SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REFERRED BY: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

NS0914 (Rev. 2010/01/25)

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OCULAR PATHOLOGY: \_\_\_\_\_

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NS0914 (Rev. 2016/03/24)