Referral Request Form

Referral hotline: 289-348-1770

HALTON VISION THERAPY CENTRE
Main office: 905-319-1066
Fax: 289-205-1466
visiontherapy@drfink.ca
www.drfink.ca

Patient Information

Name _____

Date Of Birth _____ Gender ◯ Male ◯ Female ◯ Other

Phone Number _____ Email _____

Address _____

_____

Preferred Provider _____

Type of Appointment

- ◯ Vision Therapy Assessment
- ◯ Dry Eye Consultation
- ◯ Osteopathy
- ◯ Psychotherapy
- ◯ Other: _____

Reason for Referral

- ◯ Developmental/learning disorder
- ◯ Amblyopia/Eye turn
- ◯ Binocular disorder
- ◯ Concussion/Traumatic/Acquired Brain Injury or stroke
- ◯ Uncomfortable dry eyes/itchiness/tearing
- ◯ Other: _____

Referring Practitioner Information

Name _____

Phone Number _____ Email _____

Address _____

_____

Additional Information

Please provide any additional information or special requests below.

_____

_____

_____