Ottawa Valley Vision
REFERRAL FORM
Ph: 613-633-0734
Fax: 613-212-0130
ottawavalleyvision@gmail.com

Patient Surname	**Patient First Name**	**Patient DOB (DD/MM/YYYY)**
Patient Full Mailing Address		
Patient Phone Number	**Patient Email Address**	
Patient Health Card Number		**Preferred Method of Contact (circle one)** Email / Phone

Referring Practitioner Name	**Profession**
Practitioner Mailing Address	
Practitioner Phone Number	**Practitioner Fax Number**
Practitioner Email Address	**Preferred Method of Contact (circle one)** Email / Phone /Fax

Reason For Referral (please circle all that apply)

- Eye Turn / Strabismus
- Lazy Eye / Amblyopia
- Concussion / Traumatic Brain Injury
- Stroke
- Dyslexia
- Autism
- ADHD or Other Reading Difficulty
- OTHER: _____

IMPORTANT NOTE: if the patient is being referred for a traumatic brain injury secondary to an MVA or WSIB claim, please attach a copy of the patient's insurance information.