

Motor Vehicle Accident- Intake Information

If you are a healthcare professional or a lawyers office and would like to refer your patient to our clinic for Vision Therapy, please complete the intake form below and email to vtadmin@thompsonoptometry.ca or print completed form and fax to (905) 793-8528. Please allow 48 business hours to process referrals.

Patient Full Name:		
Patient Address:		
City:	Postal Code:	
Patient Phone:	Gender:	MF
Email:		
OHIP #:	Version Code:	
Date of Birth:	Date of MVA:	

Motor Vehicle Insurance			
Company:			
Address:			
Phone/Fax:			
Adjuster:			
Claim Number:			
	Insurance Co.	Policy#	Member I.D
Other Insurance:			
(Employer; Private etc.)			

Referred By:	
Case Manager:	
OT:	
Lawyer:	
Family Optometrist:	
Other Specialists:	
Visual Symptoms Experienced:	

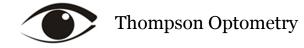


Health History				
Family Doctor:				
Any Hospitalizations:				
List of Medication:				
Do you have any allergies:	□ No		Yes. If so, please list them he	ere:
Please	check the box	es if you have any history of the f	ollowing:	
Glaucoma Glaucoma Cataracts Retinal Detachment Macular Degeneration Colour Blindness Do any of the listed items above run in your f	Stu	abetes roke thma thritis	 Heart Problems Thyroid Condition Allergies High Blood Pressure 	
	anniy ? ii so, p			
Vision/ MVA Related Questions				
Is this your first visual examination	1?	If not, when w	vas your last examination?	
Yes No		N	IM / DD / YYYY	
Have you had any eye injuries in the past?		If so	o, please explain:	
Yes No				
Have you had any eye surgeries?		If so	o, please explain:	
Yes No				
Please check the box if you have experienced any of the following at the time of the MVA/ABI:				

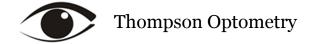


 Eye Injury Closed Head Injury Whiplash Unconscious Physiotherapy 	 CT Scan MRI Cranial Sacral Therapy Chiropractic Therapy
Please check the box if you get ov	verwhelmed or anxious in any of the following situations:
 Big Box Stores In large groups/ crowds Driving 	Public transitAround loud noises
Do you currently have a valid driver's license?	Has your driver's license ever been suspended?
Do you work currently (part time or full time)?	If not, what barriers prevent you from working?

Visual Signs & Symptoms (Physical)					
Ple	ase check the boxes if you have any h	nistory of the following:			
 Dry Eyes Burning Eyes Watery Eyes Itchy Eyes 	 Rubbing Eyes Squinting Eye Drops Eye Turn 	 Wandering Eye Eye Pain Flashes/Spot in Vision 			
Do you experience any headaches? No Yes, please explain:					
Reading					
Average reading time prior to the MVA?					
Please check the box if you have experienced any of the following since the time of the MVA/ ABI:					
 Lose place while reading Skip or re-read lines Falls asleep reading Blur reading 	 Double vision reading Shuts one eye to read Trouble comprehending things you read 	 Hold closely to read Print moves/jump Eye strain 	HeadachesDizzinessNausea		



	Hand-Eye Coord	ination	·		
Please check the bo	Please check the box if you have experienced any of the following since the time of the MVA/ ABI:				
Poor handwriting/printingDifficulty reaching for objects		Reverses/ Omits lettersDifficulty catching balls			
	Distance Vis	ion			
Please check the bo	x if you have experienced any of the fo	ollowing since the time of the MVA/	ABI:		
 Eye strain Blur Distance Vehicles appear in wrong lane 		Double vision distanceTrouble judging distance			
	Lighting				
Please check the bo	x if you have experienced any of the fo	ollowing since the time of the MVA/	ABI:		
 Light sensitivity indoors Light sensitivity in sunlight Trouble seeing in dark areas 		Glare of lights at nightLight induced headache			
Walking					
Please check the bo	x if you have experienced any of the fo	bllowing since the time of the MVA/	ABI:		
 Bumps into things/people Dizziness while moving Lose balance while walking 		 Ground does not appear Need assistive device wh etc) Trips over objects/ curb Nausea while moving 	evel		
Standing/ Sitting					
Please check the box if you have experienced any of the following since the time of the MVA/ ABI:					
 Feel dizzy while still Incomplete image of objects Lose balance easily Seeing objects or things that are 	not really there	 Objects move while sitting Nausea while sitting Nausea while standing)		
<u>Other</u>					



Please check the box if you have experienced any of the for Loses belongings Easily distracted Poor memory/ forgetful Poor concentration	 Dizzy while travelling (car) Nausea while travelling (car) Trouble comprehending things you see Trouble comprehending what you hear 		
If you have any specific comments or questions for the doctor please list them here:			