Sunshine Coast Occupational Therapy Inc.

Paediatrics, Geriatrics & Ergonomics

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Optometry/Orthoptist Referral

Referral Information

Name: _____DOB: _____ Grade:_____ Date of Referral: _____

Parent/Guardian: _____ Phone/Fax : _____

Physician: _____ Phone/Fax: _____

_____ has been identified as demonstrating the following academic difficulties possibly related to visual dysfunction:
(Child's Name)

☐ Reading ☐ Phys. Ed. ☐ Writing/Printing ☐ Math ☐ Spelling

Medical History

Visual History (previous visual assessments, training, surgeries, specialists, etc.)

_____

_____

OT Assessment Results

Bruininks-Oseretsky Test of Motor Proficiency _____

Gardner Test of Visual Perceptual Skills _____

Fine Motor Skills: _____

_____

_____

_____

Adaptations currently in place:

☐ visual filters(colored transparency/paper) ☐ scribe or tape recorder ☐ pencil/pen grip ☐ modified 'containers'

☐ adapted paper ☐ visual keys ☐ slantboard ☐ computer

(raised or highlighted lines) (L/window keys, 6"ruler finger read) ☐ photocopied notes &/or assignments

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Optometrist/Orthoptist Assessment Results

☐ Saccades ☐ Convergence ☐ Visual Fields

☐ Pursuits ☐ Suppression ☐ Ocular Dominance

☐ Accommodative Skills ☐ Refractive Status ☐ Color Vision

Optometrist/Orthoptist Recommendations

Return visit date: _____

Optometrist/Orthoptist: _____ Phone/Fax: _____