Referring Clinician:_____
Email:_____
Phone#:_____
Clinician Permission to Contact Patient Directly Y/N

Patient Name:_____
Email:_____
Phone#:_____
Date of Birth:_____

HRUSKA CLINIC VISION INTEGRATION TRIAGE FORM

Vision Information

****Once we have this information we will determine best course of action and contact you and the patient to schedule.**

Wears glasses? (Y/N)_____
If yes, when? ____Full-time ____Driving/Distance ____Reading/Near ____Computer
____Other (specify): _____
If there are no glasses, have glasses been worn/recommended in the past? (Y/N)_____
If yes, for what purpose (reading, driving, etc.)? _____
Do glasses have a bifocal? (Y/N)_____
If yes, what kind? ____Lined bifocal/trifocal ____No-line bifocal ____Other (specify): _____

Wears contacts: (Y/N)_____ If yes, when? ____Full-time ____Part-time
If part-time, when worn? _____
Type of contacts: ____Soft ____Hard/Gas Permeable ____Other (specify): _____
Is the patient in monovision correction? (Y/N)_____ Don't know_____

What is the patient's occupation?_____
How many hours per day are spent at a computer? (for business) _____(for pleasure) _____

Significant Eye/Visual History: If yes, please specify what conditions are/have been present.
Eye Disease, such as Glaucoma or Macular Degeneration? _____
Eye Trauma/surgery? _____
Please specify the procedure._____
Eye Turn/Lazy Eye?_____
Visual Field Loss/Double Vision? _____
Vision Training/Patching/PRISM use? _____
Any other significant problems? _____
Are there any times that the patient is *opposed* to wearing glasses? If yes, please specify:
_____

Please write down the last prescriptions in the spaces below: (and attach eye records)

<u>Eyeglasses</u>: Right Eye _____
Left Eye _____

<u>Contacts</u> (Brand): _____

	Right Eye	Left Eye
Base Curve:		
Power:		
Other:		

Referring Clinician:_____
Email:_____
Phone#:_____
Clinician Permission to Contact Patient Directly Y/N

Patient Name:_____
Email:_____
Phone#:_____
Date of Birth:_____

HRUSKA CLINIC VISION INTEGRATION TRIAGE FORM

PT (PRI) Information (if known)

****Once we have this information we will determine best course of action and contact you and the patient to schedule.**

Primary Complaints:_____
_____
_____

What is their habitual pattern?

____ AIC (Left or Bilateral) ____ BC (Right or Bilateral)
____ TMCC ____ PEC
____ PRI Tests that are pathologic: _____

Can you get the patient neutral at the Right BC and Right TMCC? (Y/N)_____

If yes, under what conditions? ____Manual Techniques
____Non-Manual Techniques
____Closing Eye(s) or Patching
____Dental Integration (popsicle stick, mouth-guard etc.)
____Using lenses (plus power, prisms etc.)
How?_____

Can they maintain it? (Y/N)_____

Current Footwear:_____
Orthotics? (Y/N)_____ Where were they made?_____
History of significant ankle sprains/injuries (Y/N)_____
If Y how many and which ankle?_____

Previous surgeries? (Y/N)_____If yes, please specify. _____
_____

Are they undergoing any other PRI-directed treatment, such as dental/orthodontic work?
(Y/N)_____If yes, what care? _____

Do they have a history of:

Concussions? (Y/N)_____
Cervical Injuries, whiplash, etc.? (Y/N)_____
Headaches? (Y/N)_____
Dizziness or Vertigo (Y/N)_____Has this been resolved? (Y/N)_____

Do they have an oral appliance? (Y/N)_____When is it used? ____Night ____Day
Is it a: ____ MMOO (gelb-like) _____Maxillary
____ MOOO or Flat plane mandibular _____ALF
____ other (specify): _____

Patient's Hand Dominance: Right-handed Left-handed