

FAMILY VISION CARE OPTOMETRY

Vision Rehabilitation for Traumatic Brain Injury

Our office has a unique service for those who have had a traumatic brain injury or stroke. Before your exam, we would like you to request reports from the doctors and therapists that are working with you. In order to be informed on the case, it would be most beneficial that the reports are sent to us before your office visits.

We do schedule **two** appointments because there is extensive testing that needs to be done. The cost for the first two evaluations will be \$730.00. This includes specialized testing for traumatic brain injury and stroke patients, as well as other neurological problems. The initial evaluation that we perform is two hours in length. A Visual Evoked Potential (VEP) test will be done at the second appointment. This test measures the brain waves associated with the visual system. After the examination, we will prepare a report on our findings. Recommendations for treatment will be part of the report. In some cases we will recommend neuro vision rehabilitation that is part of your program. Our office can coordinate with rehabilitation centers to provide this service. In other cases, we will provide the therapy at our office.

The cost for the services will be your responsibility. Even though you have medical coverage, the coverage may not pay for our services. We do not accept assignments for HMO or major medical coverage. Medicare will cover the majority of the costs, but there will be some out of pocket expenses. There are additional charges for reports or medical conferences. Glasses and materials are extra. Our staff will review with you what your financial responsibility is prior to the office visit. Bring your major medical card to the office. We will bill your major medical insurance for you, but payment is required at the time of the exams. Please be prepared to pay for your services at the time of your appointment.

The attached forms need to be completed as carefully as possible. Fill it out and return it to our office prior to the examination via fax or mail. Also, bring any glasses or vision aids that you are currently using on the day of your appointment. It is always helpful to have a report from your previous eye doctor.

Should you have any questions regarding our office financial responsibility policy, feel free to contact us. We look forward to meeting you.

Sincerely,
Carl Garbus, O.D., FAAO

I understand the office policy with regards to my financial obligation and agree to abide by it.

Print Name

Signature

Date of Appointment

***please do not type signature*

Family Vision Care Optometry: 28089 Smyth Drive ✕ Valencia CA 91355
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Supplemental Form - VISION REHABILITATION QUESTIONNAIRE

This form is to be filled out in addition to the general adult questionnaire if you have had traumatic brain injury or stroke. The general adult form can be found on the Printable Forms page of the website. Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 8 pages – please be sure you have completed all eight pages. Please return it to our office *prior* to your appointment by either mailing it or faxing it. THANK YOU.

Date _____

GENERAL INFORMATION

Patient's Name: _____ Male Female

Do you have Major Medical Insurance? Yes No

If yes, who is the carrier? _____

Policy#: _____

Does the insurance cover eye examinations or glasses? Yes No

Primary Insurance: _____

Policy #: _____

Secondary Insurance: _____

Policy #: _____

Social Security Number: _____

Driver's License No.: _____

MEDICAL HISTORY

Date of injury/accident: _____

Type of injury/accident:

- | | | | | |
|--|---|--|-------------------------------|--|
| <input type="checkbox"/> Motor Vehicle | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fall | <input type="checkbox"/> Medication-Related |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Carbon Dioxide | <input type="checkbox"/> Cord around neck | | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Blow to head | <input type="checkbox"/> Drowning | <input type="checkbox"/> Industrial Accident | | <input type="checkbox"/> Poison or toxic substance |
| <input type="checkbox"/> Other: _____ | | | | |

WHAT PART OF YOUR HEAD WAS AFFECTED? (Check all that apply):

Forehead Right side Left head Back head Top of head Face

Was your injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Did you lose consciousness? Yes No If yes, for how long? _____

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SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (Check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Pain in or around eyes |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Restricted Motion | <input type="checkbox"/> Restricted Field of View |
| <input type="checkbox"/> Neck pain/whiplash | <input type="checkbox"/> Other: _____ | | |

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____

Name of Doctor: _____ Specialty: _____

Where were you seen? _____

Were you hospitalized? Yes No If yes, how long? _____

What were you and your family told? _____

What did the initial treatments consist of? _____

What prognosis/recommendations were you given? _____

Where you given medications? Yes No

If yes, please list: _____

For what condition(s)? _____

List any medications, including vitamins and supplements used at the current time:

SUBSEQUENT/OTHER PROFESSIONAL CARE

What types of professional care have you received or are you currently receiving:

Physicians Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Physiatrist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Neurologist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

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Neuropsychologist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Physical Therapist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Speech / Language Therapist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Psychologist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Osteopathic Physicians Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Occupational Therapist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Optometrist / Ophthalmologist Name: _____ Date: _____

Address: _____ City _____ Zip Code: _____

Do you have a history of allergies? Yes No

If yes, please explain: _____

Has a neurological evaluation been performed? Yes No

If yes, by whom? _____

Results: _____

Has a psychological evaluation been performed? Yes No

If yes, by whom? _____

Results: _____

Has a speech and language evaluation been performed? Yes No

If yes, by whom? _____

Results: _____

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VISUAL HISTORY

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: _____

Address: _____

Reason for examination: _____

Were glasses, contact lenses, or other optical devices recommended? Yes No

If yes, what? _____

Are they used? Yes No If yes, when? _____

If not, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision? Yes No

If yes, what? _____

Did you undergo these tests, treatments, or therapies? Yes No

Explain: _____

Results and Recommendations: _____

Why do you feel the need for a vision evaluation? _____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes No

If yes, please explain (please include effects involving home, work, hobbies, social and personal relationships):

What activities comprise the majority of your daily life since your accident/injury?

What activities can you no longer engage in due to your visual or other difficulties?

What other changes/limitations in your daily life do you attribute to your accident/injury?

What do you hope a Visual Rehabilitation Program can do for you?

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EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is your current employment position? _____

If a student, what is the major course of study? _____

How many hours daily are spent at a desk? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent reading/ studying? _____

How many hours daily are spent with a computer? _____

Release of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or with the recommendation from FAMILY VISION CARE OPTOMETRY, when it is necessary for treatment of my visual condition, or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

Signature of patients or authorized representative

**please do not type signature

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 ours a day / 7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment. Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Please fill out the checklist that follows. Place a check mark in the appropriate box to assign a value for each symptom. Also place a check mark in the last column labeled "Existed Prior to Injury" if the symptom was present prior to injury.

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NEURO VISION REHABILITATION INSTITUTE

Brain Injury Checklist

Name: _____

Date: _____

		0 NEVER HAPPENS	1 OCCASIONALLY 1-2 TIMES PER MONTH	2 OFTEN 1-2 TIMES EVERY 2 WKS	3 FREQUENTLY 3-5 TIMES PER WEEK	4 ALWAYS HAPPENS	EXISTED PRIOR TO INJURY
1.	Double vision at distance						
2.	Double vision at near						
3.	Blurred vision at near						
4.	Closes or covers one eye						
5.	Sensitive to bright lights ___ Sunlight ___ Fluorescent						
6.	Has difficulty seeing in dim illumination						
7.	Difficulty changing focus far to near						
8.	Head tilted to one side						
9.	Burning or stinging eyes						
10.	Itchy eyes						
11.	Headaches associated with near work						
12.	Skipping or repeating lines when reading						
13.	Words running together when reading						
14.	Omitting small words when reading						
15.	Reading comprehension declining over time						
16.	Avoidance of reading at near work						
17.	Difficulty with writing; writing up hill or down hill						
18.	Holds reading material too close						
19.	Falling asleep when reading						
20.	Confusion/disorientation						
21.	Dizziness or nausea						
22.	Car sickness/motion sickness						
23.	Movement of objects in the environment is bothersome						

		0 NEVER HAPPENS	1 OCCASIONALLY 1-2 TIMES PER MONTH	2 OFTEN 1-2 TIMES EVERY 2 WKS	3 FREQUENTLY 3-5 TIMES PER WEEK	4 ALWAYS HAPPENS	EXISTED PRIOR TO INJURY
24.	Patterned wallpaper or carpets are bothersome						
25.	Object jumps in and out of field of view						
26.	Difficulty with peripheral vision						
27.	Poor balance						
28.	Floor looks tilted						
29.	Uncomfortable in a market or mall						
30.	Disoriented with head movements						
31.	Flashes of light						
32.	Dislikes heights						
33.	Bumps into things						
34.	Difficulty using both sides of the body together						
35.	Tendency to knock things over on desk or table						
36.	Difficulty with dressing						
37.	Difficulty with bathing/personal hygiene						
38.	Difficulty with hand tools—scissors, screwdriver, calculator, keys						
39.	Poor hand-eye coordination						
40.	Inability to estimate distance accurately						
41.	Misplaces or loses papers, objects or belongings						
42.	Difficulty following a series of directions						
43.	Forgetful or poor memory						
44.	Difficulty with time management						
45.	Difficulty with money concepts, making change						
46.	Difficulty performing tasks formerly easy/routine						
47.	Short attention span						