Health Care Professionals Referral Form

VISION LOSS REHABILITATION CANADA

Thank you for choosing to refer your patient to Vision Loss Rehabilitation Canada for assistance with their vision loss. Once we receive your referral, we will reach out to your patient to develop their rehabilitation plan.

Date of exam: _____/_____/_____ Patient's D.O.B.: _____/_____/_____
year month day year month day

Patient's last name:_____ Patient's first name:_____

Patient's address:_____/_____/_____/_____
street city province postal code

Patient's phone: _____

Prov. Health Card No.: _____

Patient consented to release of vision information: ☐ Date consent given: ____/____/___

Alternate contact name: _____ Phone:_____

If person giving consent is not patient, note name here:_____

Distance BCVA: OD: _____ OS: _____ OU: _____

Near BCVA: OD: _____ OS: _____ OU: _____

Visual Field: ☐ Abnormal ☐ Normal If abnormal, note field loss (degrees) :
OD: _____ OS:_____

Field loss type (e.g Hemianopsia): _____

Primary condition/cause of vision loss: OD: _____ OS:_____

Secondary condition/cause of vision loss: OD: _____ OS:_____

Reason for referral: _____

Current correction if known OD: _____ OS: _____

☐ optometrist ☐ ophthalmologist
Name: _____ ☐ Other health care professional

Clinic/Office address: _____/_____/_____/_____
street city province postal code

Phone: _____ Fax: _____

Signature: _____ License to practice #: _____

Additional comments (e.g. contrast sensitivity/3rd eye condition):

_____