

VISION LOSS REHABILITATION™

CANADA

Community/Self-Referral Form

Thank you for choosing Vision Loss Rehabilitation Canada. Whether you're making a referral for yourself, a client, or someone you care about, we're here to offer support.

We encourage you to complete all fields on this form so we can build the best possible rehabilitation plan.

Please send this completed form by fax to 1-844-268-7294. *Indicates all required fields.

Person's Information	
*Date of Referral	
Person's Health Card #	
*Person's Legal Name	
*Person's address 1	
Person's address 2	
*Person's City	
*Person's province	
*Person's Postal Code	
*Person's Telephone # (Daytime or Cell)	
*Person's Date of birth (YYYY-MM-DD)	

1 *How does the person's vision loss impact their quality of life?

Safety- Have you had a fall recently within the last 3 months due to your vision loss? Yes No

Have you burned yourself due to your vision loss? Yes No

Job/academic- Are you at risk for losing your job due to your vision loss? Yes No

Are you at risk for academic failure due to your vision loss? Yes No

Daily living- Have you taken the wrong medication due to your vision loss? Yes No

Other Reason for the Referral:

2 *Have they had a visit with their eye doctor in the last year?

Yes

No

Diagnosis:

Eye Doctor's Name:

3 *Is the person currently in a hospital or rehabilitation facility?

Yes

No

4 If yes, is this referral part of the discharge plan?

Yes

No

5 Is there additional assessment information to accompany this referral?

Rai HC/CHA

No

Health Care Assessment

Other:

6 *Person's preferred language:

English

Other (Please specify):

French

Consent

7 *Has the person been made aware of this referral and provided their consent?

No

Yes

Date consent was given (DD/MM/YY):

If consent was provided by someone other than the person being referred:

Alternate contact name:

Relationship:

Daytime contact number:

Referral Agency Information

*Referral Completed by:

Agency/Worker

Self-Referral

Family Referral

*Name of Person Making Referral:

*Organization/Relationship:

Phone #: