VISION LOSS REHABILITATION™ CANADA

RÉADAPTATION EN DÉFICIENCE VISUELLE℠ CANADA

Eye Care Professional - Referral Form

Thank you for choosing Vision Loss Rehabilitation Canada. We're here to offer support as you refer your patient. Please complete all fields on this form so we can build the best possible rehabilitation plan.

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

Referral date: _____

Section one: Patient Information

*VLRC office closest to patient: --select one --

*Health Card #		*Date of Birth (YYYY-MM-DD)	
*Surname		*First Name	
Gender			
*Address 1		Address 2	
*City/Town		*Province/Territory	
*Phone #		Alternative phone #	
Email			
Preferred language		If other, please specify	
Alternate contact name		Phone # of alternate contact	

Section two: Supplemental patient information

1. Does the patient identify as an Indigenous person, such as First Nation, Inuk (Inuit), or Métis?
   Yes ☐ No ☐

2. If yes, please provide **ONE** of the following:
   A. First Nations
      Indian Act Registration (Status) Number: _____, or
      NIHB provided ID number (B-number): _____

   OR

   B. Metis
      Band Number + Family Number (no spaces): _____,
      Indian Act Registration (Status) Number: _____,

   OR

   C. Inuk (Inuit)
      Northwest Territories health plan number: _____, or
      Government of Nunavut health plan number: _____, or
      NIHB client identification number (N-Number): _____

3. Is the patient a current, former or retired member of the Canadian Armed Forces or the Royal Canadian Military Police (RCMP)?

   Yes ☐ No ☐ Unknown ☐_

4. If yes, can they provide a K-number?

   Yes ☐ K number:
   No ☐ Unknown ☐_

Section three: Reason(s) for referring the patient

Impact of vision loss on the patient's quality of life (e.g., safety, job/academic, daily living, other):

1. Due to the patient's vision loss, have they experienced a fall within the last 3 months?
   Yes ☐ No ☐ Unknown ☐_
2. Due to the patient's vision loss have they experienced burns?
   Yes ☐ No ☐ Unknown ☐_

3. Due to the patient's vision loss, are they at risk of job loss?
   Yes ☐ No ☐ Unknown ☐
4. Due to the patient's vision loss, are they at risk of academic failure?
   Yes ☐ No ☐ Unknown ☐
5. Due to the patient's vision loss, have they accidentally taken the wrong medication?
   Yes ☐ No ☐ Unknown ☐

Section four: Eye examination

1. * **Has there been an eye examination within the last 12 months?**
   Yes ☐ No ☐ Unknown ☐
   Examination date:
   Eye Doctor's Name:
   Diagnosis:

Section five: Patient vision information (to be completed by eye care professional)

Date of exam: _____
Prescriber name: _____

Distance VA (best corrected).
OD (right eye): -none-
OS (left eye): -none-
OU (both eyes): -none-

Near VA (best corrected).
OD (right eye): -none-
OS (left eye): -none-
OU (both eyes): -none-

Rx OD (right eye): _____
Add: _____

Rx OS (left eye): _____
Add: _____

Current correction:

☐ Current correction is the same as the Rx for both OD and OS

Current Correction - OD (right eye): _____
Add: _____
Current Correction - OS (left eye): _____
Add: _____

Visual field:

Visual field -- none --

Describe field loss - OD (right eye) Visual field in degrees: -- none --

Field loss description: -- none --

Describe field loss - OS (left eye) Visual field in degrees: -- none --

Field loss description: -- none --

Primary cause of vision loss:

OD (right eye): Other

OS (left eye): Other

Secondary cause of vision loss:

OD (right eye): Other

OS (left eye): Other

Primary functional reason for referral (e.g., patient struggles to read print)

Other medical conditions or limitations:

- ☐ Diabetes
- ☐ Stroke
- ☐ Depression
- ☐ Dementia
- ☐ MS

Other: _____

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Section six: Consent

* Is the patient aware of this referral and has provided their consent to release their information to VLRC? Yes ☐ No ☐

Date of consent:

If consent is provided by a substitute decision-maker, please complete the following:

Consenting person's surname _____ First name: _____

Relationship to patient: _____

Daytime phone #: _____

Date of substitute consent: _____

Section seven: Eye care professional's information

I am an:

Ophthalmologist ☐ Optometrist ☐ Neuro-ophthalmologist ☐

Other eye care professional ☐

License to practice # __

*Surname		*First name	
*Clinic or office address 1		Clinic or office address 2	
*City/Town		*Province/Territory	
*Postal Code		*Email	
*Phone #		Fax #	