VISION LOSS REHABILITATION™ CANADA

RÉADAPTATION EN DÉFICIENCE VISUELLE™ 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.

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

Referral date: _____

Section one: Please provide the information of the person being referred:

Health Card #	
*First and Last Name	
Gender	
*Address 1	
Address 2	
*City	
*Province	
*Postal Code	
E-mail address	
*Telephone # (Daytime or Cell)	
*Date of birth (YYYY-MM-DD	
Preferred language	If other, please specify _____

Section two: Supplemental personal information

1. Do you (the person being referred) 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. Are you (or the person being referred) 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 you provide a K-number?
   Yes ☐ K number:
   No ☐ Unknown ☐

Section three: Reason for referral

How does the person's vision loss impact their quality of life (e.g., safety, job/academic, daily living, other):

1. Due to your vision loss, have you (the person being referred) fallen within the last 3 months?
   Yes ☐ No ☐ Unknown ☐
2. Due to your vision loss, have you (the person being referred) burned yourself?
   Yes ☐ No ☐ Unknown ☐
3. Due to your vision loss, are you (the person being referred) at risk of losing your job?
   Yes ☐ No ☐ Unknown ☐
4. Due to your vision loss, are you (the person being referred) at risk for academic failure?
   Yes ☐ No ☐ Unknown ☐
5. Due to your vision loss, have you (the person being referred) taken the wrong medication?
   Yes ☐ No ☐ Unknown ☐

If you answered yes to any of the above questions, please explain:

Section four: Eye examination and additional information

1. *** Has there been an eye doctor examination in the past 12 months?**
   Yes ☐ No ☐ Unknown: ☐

Eye Doctor's Name: ____

Diagnosis:

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

Section five: Consent

1. * If you are referring yourself, do you consent to releasing your information to VLRC?

   Yes ☐ Date of consent: ___

   No ☐ Not applicable ☐

2. * If you are referring someone, are they aware of this referral and have provided their consent to release their information to VLRC?

   Yes ☐ Date of consent: ___

   No ☐ Not applicable ☐

3. If a substitute decision-maker is providing consent on behalf of the person being referred, please complete the following:

   Consenting person's surname _____ First name: _____

   Relationship to patient: _____ Daytime phone #: _____

   Date of substitute consent: _____

Section six: Referring agency information

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

2. *Name of Person Making Referral: _____

   *Organization/Relationship: _____

   Phone Number #1: _____ Ext.: _____

   Phone Number #2: _____ Ext.: _____

   E-mail: _____

   *Referral Completed by:

   ☐ Agency/Worker

   ☐ Family Referral