VISION LOSS REHABILITATION™ CANADA

RÉADAPTATION EN DÉFICIENCE VISUELLE[MC] 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: _

Health Card #		*Date of Birth (YYYY-MM-DD)	
*Last Name		*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 Mounted 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):
OS (left eye):
OU (both eyes):

Near VA (best corrected).
OD (right eye):
OS (left eye):
OU (both eyes):

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

Describe field loss - OD (right eye) Visual field in degrees:

Field loss description:

Describe field loss - OS (left eye) Visual field in degrees:

Field loss description:

Primary cause of vision loss:

OD (right eye):

OS (left eye):

Secondary cause of vision loss:

OD (right eye):

OS (left eye):

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

Other medical conditions or limitations:

Diabetes
Stroke
Depression
Dementia
MS
Other: ___________________________________

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 last name _____________ First name: __________
Relationship to patient: __________
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 # __

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