VISION LOSS REHABILITATION™ CANADA

RÉADAPTATION EN DÉFICIENCE VISUELLE℠ CANADA

Health Care Professional Referral Form

Thank you for choosing Vision Loss Rehabilitation Canada. We're here to offer support as you complete your referral. 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)	
*Last Name		*First Name	
Gender	Other		
*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

1. * Impact of vision loss on the patient's quality of life (e.g., safety, job/academic, daily living, other):
   a. Due to the patient's vision loss, have they experienced a fall within the last 3 months? Yes ☐ No ☐ Unknown ☐
   b. Due to the patient's vision loss, have they experienced burns?
      Yes ☐ No ☐ Unknown ☐
   c. Due to the patient's vision loss, are they at risk of job loss?
      Yes ☐ No ☐ Unknown ☐

d. Due to the patient's vision loss, are they at risk of academic failure?
Yes ☐ No ☐ Unknown ☐

e. Due to the patient's vision loss, have they accidentally taken the wrong medication?
Yes ☐ No ☐ Unknown ☐

2. * Reason for referral (describe functional problems related to vision, e.g., the person struggles to read print):

3. Other medical conditions or limitations
☐ Diabetes
☐ Stroke
☐ Depression
☐ Dementia
☐ MS
Other: _____

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 ☐

3. Is there additional assessment information to accompany this referral?
Rai HC/CHA ☐ No ☐
Health Care Assessment ☐ Other _____

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Section five: Consent

* Is the person aware of this referral and has provided their consent?

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: _____

Daytime phone #: _____

Date of substitute consent: _____

Section six: Referrer information (select one)

I am a(n):

☐ Health care professional (please specify): _____

☐ Educator ☐ Employer ☐ Other ____

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