Community/Self-Referral Form

VISION LOSS REHABILITATION CANADA

Thank you for choosing Vision Loss Rehabilitation Canada. Whether you are making a referral for yourself, a client, or someone you care about, we are here to offer support. We encourage you to complete all fields on this form so we can build the best possible rehabilitation plan. Please return the completed form by fax to 1-844-268-7294.

Referral Date: ____/____/____ (year/month/day)

Referred Individual's Information

Last name: _____ First name: _____

D.O.B.: ____/____/____ (year/month/day) Prov. Health Card No.: _____

Address: _____/_____/_____/_____ (street / city / province / postal code)

Phone #: _____ Alternative phone #: _____

Email address:

Alternate Contact's Name: _____ Alternative Contact's Phone #: _____

Does the individual identify as an Indigenous person, that is, First Nation, Inuk (Inuit), or Metis? Yes ☐ No ☐ If yes, ID #:

Is the individual a current, former, or retired member of the Canadian Armed Forces or the Royal Canadian Military Police? Yes ☐ No ☐ If yes, K #: _____

Consent

The individual consented to the release of vision information: Yes ☐ No ☐ Consent Date: ____/____/____ (year/month/day)

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

Consenter's last name: _____ Consenter's first name: _____

Relationship: _____ Consenter's phone #: _____

Date substitute consent was given: ____/____/____ (year/month/day)

Reason(s) For Referring the Individual

Due to the individual's vision loss, have they experienced a fall within the last 3 months?	Yes ☐ No ☐ Unknown ☐
Due to the individual's vision loss, have they experienced burns?	Yes ☐ No ☐ Unknown ☐
Due to the individual's vision loss, have they experienced taking the wrong medication?	Yes ☐ No ☐ Unknown ☐
Due to the individual's vision loss, are they at risk of job loss?	Yes ☐ No ☐ Unknown ☐
Due to the individual's vision loss, are they at risk of academic failure?	Yes ☐ No ☐ Unknown ☐

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

_____

_____

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

Eye Doctor's Name: _____ Diagnosis: _____

Is the individual currently in a hospital or rehabilitation facility? Yes ☐ No ☐

If yes, is this referral part of the discharge plan? Yes ☐ No ☐

Referrer Information

Note: if you are self-referring, you do not need to complete this entire section and only need to check the self-referral box if the contact information is the same as the Referred Individual's Information section.

Last name: _____ First name: _____

Address: _____/_____/_____/_____
street city province postal code

Phone #: _____ Email address: _____

I am a(n): Agency/Worker ☐ Self-Referral ☐ Family Referral ☐ Other ☐
Please specify: _____

Organization: _____ Relationship: _____