Eye Care Professional Referral Form

VISION LOSS REHABILITATION CANADA

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. Please return the completed form by fax to 1-844-268-7294.

Date of Exam: ____/_____/_____ (year/month/day) Referral Date: ____/_____/_____ (year/month/day)

Patient'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 patient identify as an Indigenous person, that is, First Nation, Inuk (Inuit), or Metis? Yes ☐ No ☐ If yes, ID #: _____

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

Consent

The patient 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)

Eye Condition Information

Distance BCVA: OD: _____ OU: _____

Near BCVA: OD: _____ OS: _____ OU: _____

Visual field: Abnormal ☐ Normal ☐

If abnormal, indicate field loss (degrees): OD: _____ OS: _____

Field loss type (for example, Hemianopsia):

Primary condition/cause of vision loss: OD: _____ OS: _____

Secondary condition/cause of vision loss: OD: _____ OS: _____

Current correction (if known): OD: _____ OS: _____

Reason for referral (describe the functional problems related to vision; for example, the person struggles to read print):

_____

_____

Referrer Information

Last name: _____ First name: _____

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

Phone #: _____ Email address: _____

Fax #: _____ License to practice #:

I am a(n): Optometrist ☐ Ophthalmologist ☐ Neuro-Ophthalmologist ☐ Other ☐
Please specify: _____

Signature: _____