Health Care Professional Referral Form

VISION LOSS REHABILITATION CANADA

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

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 ☐ ☐ 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

Reason(s) For Patient's Referral

Due to the patient's vision loss, have they experienced a fall within the last 3 months? Yes ☐ No ☐ Unknown ☐

Due to the patient's vision loss, have they experienced burns? Yes ☐ No ☐ Unknown ☐

Due to the patient's vision loss, have they experienced taking the wrong medication? Yes ☐ No ☐ Unknown ☐

Due to the patient's vision loss, are they at risk of job loss? Yes ☐ No ☐ Unknown ☐

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

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

_____

_____

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

Eye Doctor's Name: _____ Diagnosis:

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

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

Is there additional assessment information to accompany this referral?

Rai HC/CHA: Yes ☐ No ☐ Health Care Assessment: Yes ☐ No ☐

Referrer's Information

Last name: _____ First name: _____

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

Phone #: _____ Email address: _____

I am a(n): Healthcare professional ☐ Educator ☐ Employer ☐ Other ☐
Please specify: _____ Please specify: _____