Health Care Professionals Referral Form



Thank you for choosing to refer your patient to Vision Loss Rehabilitation Canada for assistance with their vision loss. Once we receive your referral, we will reach out to your patient to develop their rehabilitation plan.

Date of exam: _	/_ _year month		ent's D.O.B.:	/	
Patient's last nam	ne:	-	ent's first nar	_	
Patient's address		/		, ,	
ratient's address	: street		city	// province	postal code
Patient's phone: _					
Prov. Health Card	l No.:				
Patient consented	l to release of visio	n informatio	n: 🗌 Date co	nsent given:	//
Alternate contact	name:		Pho	ne:	
If person giving o	consent is not pation	ent, note nar	ne here:		
Distance BCVA	: OD:	OS: _		OU:	
Near BCVA:	OD:	OS: _		OU:	
OD:	Abnormal □ Norr OS: (e.g Hemianopsia)		-		•
Primary condition/cause of vision loss: OD:				OS:	
Secondary condition/cause of vision loss: OD:				OS:	
Reason for refe	erral:				
Current correct	tion if known OD:		OS:		
Name:				etrist	_
Clinic/Office addr	ess:street	/		/	_/
	street		city	province	postal code
Phone:		F	ax:		
Signature:		Lice	_ License to practice #:		
Additional comme	ents (e.g. contrast	sensitivity/3	Brd eye condi	tion):	