

 **Community Referral Form**

 **Community/Family/Self-Referral:**

**Please fill out the questions below to the best of your ability. Questions relate directly to yourself or the individual you are referring.**

1. Do you or the person you are referring have difficulty with vision? ** Yes  No**

2. Does vision loss make it challenging to do things on a day-to-day basis? (i.e. reading

 the newspaper, preparing meals, banking, personal care, navigating stairs/curbs, etc.)

 ** Yes  No**

3. Has vision loss increased the risk of falls and or injuries? Please consider both inside and outside the

 home.

 ** Yes  No**

4. Due to vision loss is there an increased risk for isolation and depression?  ** Yes  No**

5. Has the individual being referred (or self) visited an eye doctor in the past year? ** Yes  No**

 Eye Doctor’s Name:

6. Is the individual being referred (or self) currently in a hospital or rehabilitation facility?  ** Yes  No**

 Is this referral part of the discharge plan? ** Yes  No**

**For Community Referrals:**

7. Is there additional assessment information to accompany this referral? ** Yes  No**

 Description:

8. Is the person aware of this referral and provided consent? ** Yes  No**

 Date consent given: ­­­­­­­­­­­­­­­­­­­­

If consent provided by someone other than the person being referred, please complete:

 Alternate contact name:

 Relationship to referred: Day time contact number:

***Required: Please complete the following information for individual being referred.***

Form completed by referring: Agency **** Worker **** Family Member **** Self-Referral ****

Client Name: Referral Date:

Client Phone: Client Email:

Referring Organization/Relationship: