

South East Ontario Vision Rehabilitation Service (SOVRS)



Referral Form

Please fax to
(1)-613-542-8639

Patient Information or Label

Name: _____ Street Address: _____

Health Card #: _____

DOB: _____ City: _____

Phone: _____ Postal Code: _____

Alternative contact (name, relationship, phone #): _____

Patient or substitute decision maker consents to release of vision information to SOVRS

Diagnoses (1° & 2°) OD: AMD Diabetes Glaucoma Other: _____

OS: AMD Diabetes Glaucoma Other: _____

Best Corrected Visual Acuity: OD: OS: OU:

Visual Field: Normal Abnormal; field loss type: _____ Field loss (degrees): _____

*** please attach visual field reports if available ***

Date of last eye exam: _____

Additional comments (or attach additional documentation):

Reason for referral:

Optional: The patient meets the requirements for legal blindness Yes No

Visual acuity is 20/200 (6/60) or less (Snellen or an equivalent) OR field of vision is 20 degrees or less

Referral Source: Ophthalmologist Optometrist Other healthcare professional: _____

Name: _____ License to practice # (as applicable): _____

Contact (e.g., phone, clinic address, email): _____

Signature: _____ Date: _____

Family MD / NP (if not referral source): _____ Phone #: _____

Eye doctor name (if not referral source): _____ Phone #: _____

Eye doctor's signature (as available): _____