South East Ontario Vision Rehabilitation Service	Referral Form
Kingston Health Sciences Centre Centre des sciences de la santé de Kingston VISION LOSS REHABILITATION ONTARIO RÉADAPTATION EN DÉFICIENCE VISUELLE ONTARIO	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

Diagnosis **OD:** ☐ AMD ☐ Diabetes ☐ Glaucoma ☐ Other: ____________

OS: ☐ AMD ☐ Diabetes ☐ Glaucoma ☐ Other: ____________

Best Corrected Visual Acuity: OD: 6/ OS: 6/ OU: 6/

Visual Field: ☐ Normal ☐ Abnormal; field loss type: ____________ Field loss (degrees): ______

Additional comments (or attach additional documentation):

Date of last eye exam: ______________________

Reason for referral:

Referral Source: ☐ Ophth. ☐ OD ☐ Other healthcare professional: ______________________

Name:______________________ License to practice # (as applicable): ____________

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

Signature: ______________________

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

Eye doctor's signature (if available): ______________________