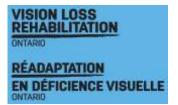
South East Ontario Vision Rehabilitation Service





Referral Form

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

Referrals: 613-542-4975 ext. 5081; Inquiries: 613-544-3400 ext. 2475

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): 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:	 -
	Phone #:
	Phone #:
Eye doctor's signature (if available):	