South East Ontario Vision Rehabilitation Service

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

VISION LOSS REHABILITATION ONTARIO
RÉADAPTATION EN DÉFICIENCE VISUELLE ONTARIO

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

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): _____
*** please attach visual field reports if available ***

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: _____

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

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

Eye doctor's signature (if available): _____