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: ______________________

Postal Code: ______________________

Phone: ______________________

☐ 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: 6/ OS: 6/ OU: 6/

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:

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): ______________________