

## 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): \_\_\_\_\_

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): \_\_\_\_\_