Hamilton, Brant, Haldimand Norfolk, Niagara
Phone 905 385-7927 ext. 240
Fax # 905 385-3244

Blind-Low Vision
Early Intervention Program

REFERRAL FORM

Age 0 – School Entry *or* Up to Age 6 if NOT in School

☐ Referral to program
☐ Consent received to send to the Regional Blind Low Vision Program

CLIENT AND CONTACT INFORMATION

Child's First Name:	Gender:
Child's Last Name:	DOB:
Contact Name:	
Relationship to Child:	
Language Spoken:	☐ Interpreter Required
Day-time Tel:	Other Tel:
Email Address:	
Street Address:	Apt/Unit:
City:	Postal Code:

SOURCE OF REFERRAL/REPORT

☐ Ophthalmologist ☐ Optometrist ☐ Medical Practitioner
☐ Other Professional ☐ Family

Name:	Title:
Organization:	
Tel: Ext.	Fax:

EYE INFORMATION

Primary cause of vision loss: OD: OS: OU:

Other ocular diagnosis (if any):

Suspected CVI:

Vision expected to be: ☐ Stable ☐ Progressive

Comments (i.e. Observations, VEP, ERG results, etc.):

OTHER RELEVANT INFORMATION

☐ Other Medical Diagnosis:

Comments (i.e. observations, relevant info, etc.):

☐ Report attached

Signature (Referring Practitioner):

Date:

Fax to 905-385-3244
PLEASE FORWARD REPORTS/TEST RESULTS WITH THIS REFERRAL FORM.

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