Blind-Low Vision
Early Intervention Program

Hamilton, Niagara, Brant, Haldimand-Norfolk
Phone 905 385-7927 ext. 221 1 866-826-4327 ext. 221
Fax # 905 385-2778

0 – 6 years old

REFERRAL FORM

☐ Referral to program / initial report ☐ Update Report
☐ Consent received to send to the Regional Blind Low Vision Program

CLIENT AND CONTACT INFORMATION

Child's Name: first/last	Gender:	DOB: d/m/y
Contact Name:		
Relationship to child:		
Day-time Tel:	Other Tel:	
Street Address:		Apt/Unit:
Town:	P.C.	

SOURCE OF REFFERAL/REPORT

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

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

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EYE INFORMATION (if completed by Ophthalmologist/Optometrist)

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

Other ocular diagnosis (if any):

Suspected CVI:

Vision expected to be: ☐ Stable ☐ Progressive

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

OTHER RELEVANT INFORMATION

☐ Confirmed Autism ☐ Hearing Loss

☐ Other Medical Diagnosis:

Other comments (i.e. observations, relevant info, etc.):

☐ **Report attached**

Signature (Referring Practitioner):

Date:

PLEASE FORWARD REPORTS/TEST RESULTS WITH THIS REFERRAL FORM.

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