Travelling Low Vision Clinic for Alberta

Comprehensive Low Vision Assessment for Children in Alberta

REFERRAL FORM

In order for the referral to be processed all fields of this form must be completed and signed. Thank you!

Child's Name: Gender: ☐ M ☐ F (select one)

Date of Birth: Alberta Health #

Parents/Guardians:

Home Address:
Street City Postal Code

Home Phone: Home Email:

School District:

School: Address:

Grade: Phone: Principal:

Teacher: Teacher's email:

Vision Consultant: Phone/email:

Learning Support Coordinator:

Other Therapists:
(Occupational Therapist, Physical Therapist, Speech and Language Pathologist)

Name of referring physician, school or agency:

Name: Phone:

Date of Referral:

Traveling Low Vision Clinic Partners:

Alberta Children's Hospital Foundation · Government of Alberta Education · Alberta Health Services

Name of family ophthalmologist/optometrist:

****Please include a copy of the most recent ophthalmological report, if available**

Date of last eye appointment:

Diagnosis/ Eye condition:

Distance Acuity: Near Acuity:

Medical Issues (e.g. allergies) and/or Special Medication Needs:

Has this child been referred to the CNIB? ☐ Yes ☐ No ☐ I do not know

Parental Consent:

☐ I give consent for my child to participate in the Travelling Low Vision Clinic.

Parent/Guardian: Date:

Person completing referral:

Name: Date:

Please select below where the TLVC location will be that you wish to attend:

☐ Edmonton ☐ Calgary ☐ Red Deer

☐ Stony Plain ☐ Lethbridge ☐ Medicine Hat

☐ Grande Prairie

We looking forward to seeing you!

Start Over

Email or scan this form to edc.ssvi@gov.ab.ca

with completed School and Parent Questionnaires

Print

Save File

Traveling Low Vision Clinic Partners:

Alberta Children's Hospital Foundation

Government of Alberta – Education

Alberta Health Services