Travelling Low Vision Clinic for Alberta

Comprehensive Low Vision Assessment for Children in Alberta

REFERRAL FORM 2015-2016

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:

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:

☐ Bonnyville	☐ Calgary	☐ Red Deer
☐ Edmonton	☐ Lethbridge	☐ Medicine Hat
☐ St. Albert		

We looking forward to seeing you!

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

with completed School and Parent Questionnaires

Start Over

Print

Save File

Traveling Low Vision Clinic Partners:

Alberta Children's Hospital Foundation

Government of Alberta – Education

Alberta Health Services