BLIND-LOW VISION EARLY INTERVENTION PROGRAM
Tel: 416-338-8255 TTY: 416-338-0025 **Fax: 416-**696-3450

REFERRAL / INTAKE FORM

☐ **Consent received to send to the Blind-Low Vision Program** **Date of Referral**(y/m/d) _____

Client First name

Last Name _____

Frist Name _____

Gender Male ○ Female ○

Date of Birth (y/m/d) _____

Service Language English ○ French ○

Other _____

Interpreter required Y ○ N ○

Address _____

_____

Parent/Guardian _____

Family Composition _____

Home Phone _____

Other Phone _____

Vision Concerns / Reason for Referrals

_____

_____

_____

_____

_____

Visual Impairment Diagnostic

_____

_____

Rx

○ Ophthalmologist ○ Optometrist

Name _____

Medical Diagnosis & Medication

_____

_____

_____

Hearing Concerns

_____

_____

_____

Growth & Development

1. speech/language

_____

2. gross motor

_____

3. fine motor

_____

Child's Daily Program

○ Childcare ○ Nursery School/Drop-In
○ Home ○ School
○ Rehab ○ Inpatient

Name of childcare and/or school _____

Contact Name _____

Address _____

Phone Number _____

Other Agencies Involved

Name of Agency _____

Contact person _____ Phone Number _____

Services being provided _____

Name of Agency _____

Contact person _____ Phone Number _____

Services being provided _____

Name of Agency _____

Contact person _____ Phone Number _____

Services being provided _____

Name of Agency _____

Contact person _____ Phone Number _____

Services being provided _____

Name of Agency _____

Contact person _____ PhoneNumber _____

Services being provided _____

Other Follow Up / Wait list

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Referral Source

☐ **Please contact for initial joint visit**

Name _____

Agency _____

Address _____

_____

_____

Phone _____

Personal information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 5. The information is used by the Blind Low Vision Early Intervention Program for follow-up and support services. Questions about this collection can be directed to: Health Promotion Consultant, Quality Assurance, Healthy Families / Healthy Living, 277 Victoria St., 3rd Floor, Toronto, ON, M5B lW2 or by telephone: 416-338-7600.