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RETINA CENTRE OF OTTAWA

LOW VISION CLINIC- REFERRAL FORM

Please note that visual acuity (BCVA) must be **20/50 or worse** in the better eye and have a valid OHIP card to be seen in the low vision clinic.

Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____
Month Day Year

Patient Address: _____
Street

_____ _____ _____
City Province Postal Code

Patient Phone: (_____) _____-_____ **Alternate Phone:** (_____) _____-_____

Best Corrected Visual Acuity:	OD	
	OS	
Primary Functional Reason for Referral: (check all that apply)		
☐ Difficulty Reading	☐ Difficulty Sewing/Knitting	
☐ Difficulty Watching TV	☐ Difficulty Recognizing faces	
☐ Other (please specify)		

Please include the following:
☐ Most Recent Visual Field

Referring Doctor:
Address: _____
Street

_____ _____ _____
City Province Postal Code

Phone: (_____) _____-_____ Fax: (_____) _____-_____

Signature: _____