# TRI-REGIONAL BLIND-LOW VISION EARLY INTERVENTION PROGRAM
## REFERRAL FORM

### CLIENT AND CONTACT INFORMATION

| | | |
|---|---|---|
| Child's Name: first/last | | Gender: M F DOB: dd/mm/yyyy |
| Parent/Guardian: | | Relationship to child: |
| Tel (H): | Tel (C): | |
| Address: | Town/City: | P.C.: |

| PARENT/GUARDIAN INFORMATION | REFERRAL INFORMATION |
|---|---|
| Name of Parent/Guardian Primary Contact | Name of Person Making Referral |
| Address: ☐ same as above | Title: |
| Town: PC: | Organization: |
| Tel (H): | Tel: |
| Tel (C): | Relationship to child: |

### VISION INFORMATION

Visual impairment diagnosis:

Additional ocular diagnosis (if any):

**Cortical/Cerebral visual impairment (CVI):** _____ CVI Suspected: _____ N/A: _____

Does the child have an ophthalmologist? ☐ yes ☐ no

If yes, Name: Agency:

Other Diagnoses (if known):

**All children aged birth to school entry with a visual impairment are eligible for service in Ontario.**

Eligibility: A child is eligible for the services if one or more of the following exists:

- ☐ A potential ***visual acuity*** of no better than 20/70 in the better eye after correction (estimation of acuity is acceptable)
- ☐ **Visual field restrictions** to 20 degrees or less.
- ☐ Reduced visual abilities due to **neurological issues** including cortical / cerebral visual impairment, delayed visual maturation, or hemianopsia.

Referrals can be made by anyone; however the presence of one or more of the conditions listed above must be confirmed by an ophthalmologist or optometrist.

**How to Refer**

**Fax completed referral form to:**

*Child Development Programs, Blind Low Vision Early Intervention Program*
*Fax: 905-472-7553*

**Mail completed referral form to:**

*Child Development Programs, Blind Low Vision Early Intervention Program*
*Markham Stouffville Hospital, 379 Church St., Suite 309, Markham, ON L6B 0T1*

**Contact us directly at:** 905-472-7373 x 6451 or Central Intake: 1-888-703-KIDS to make the referral over the telephone.