# Children's Low Vision Project of British Columbia

BRINGING COMPREHENSIVE LOW VISION ASSESSMENT SERVICE TO BRITISH COLUMBIA CHILDREN

Central Okanagan Public Schools
Together We Learn

## OPHTHALMOLOGISTS / OPTOMETRISTS REFERRAL FORM

**** A recent eye report can be submitted in lieu of this form****

Patient Name: _____
Address: _____
City: _____
Phone: _____
BC Medical #: _____
Date of Birth: _____

Referring MD/OD: _____
Address: _____
_____
Phone: _____
Fax: _____

**Ocular Diagnosis:** _____
_____

**Systemic Diagnosis:** _____
_____

**Visual Function Complaints:** ☐ Photophobia ☐ Nyctalopia ☐ Blur ☐ Mobility ☐ Colour ☐ Other (please list) _____

**Previous Low Vision Evaluation:** ☐ Yes ☐ No Date/Location (if available _____

**Low Vision Adaptations/Devices Currently Used:**
☐ Hand-held magnifiers ☐ Monocular Telescope ☐ Large Print ☐ Braille ☐ Don't Know ☐ Other _____

### EXAMINATION

**Vision:** ☐ *With glasses* ☐ *Without glasses*

| | Distance | Near |
|---|---|---|
| **OD** | | |
| **OS** | | |
| **OU** | | |

**Refraction / Current Glasses:**

☐ Manifest _____ OD
☐ Cycolplegic _____ OS
Current Glasses
☐ None _____ OD
_____ OS
Date of Last Eye Exam: _____

☐ Teller Cards ☐ Snellen ☐ Lea ☐ Allen ☐ Other _____

If normal, please ✓ box. If abnormal, please describe:

☐ Pupils: _____
☐ Motility: _____
☐ Anterior Segment: _____
☐ Fundus: _____

**Testing and Results** (if abnormal, please describe)

| *Test* | *Normal* | *Not Performed* | *Results:* |
|---|---|---|---|
| ERG | ☐ | ☐ | _____ |
| VEP | ☐ | ☐ | _____ |
| COLOUR | ☐ | ☐ Test type: | ☐ Ishihara ☐ Chip test (i.e. Dis) ☐ Hardy Rand Rittler |

OTHER (please specify) _____
_____