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: _____

Date of Birth: _____

Referring MD/OD: _____

Date of Exam: _____

Address: _____

Phone: _____

Fax: _____

BC Medical # _____

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 _____

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) _____

_____