TRI-REGIONAL BLIND – LOW VISION PROGRAM

General Referral Form

Child Information	
Child's name (last/first):	
DOB:	Gender:
Grade (if in school):	Name of school:
Other agencies involved:	

Family Information		Referral Information
Name of Parent/ Primary Contact		Name of Person Making Referral
Address:		Title
Town:	PC	Organization:
Tel:		Tel:
Tel other:		Relationship to child:

Vision Information

Reason for Referral:

Does the child have an ophthalmologist? ☐ yes ☐ no

If yes, Name: Agency:

Eye Diagnosis (if known):

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

- ☐ Visual Acuity of no better than 20/70 in the better eye after correction
- ☐ Visual Field restriction to 20 degrees or less
- ☐ A physical condition of the visual system which cannot be medically corrected and as such affects visual functioning to the extent that specially designed intervention is needed. The criterion is reserved for special situations such as, cortical visual impairment, delayed visual maturation and/ or a progressive visual loss where acuity and field deficits alone may not meet the criteria.

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

Fax to: Central Intake at 905-762-2115 (in Oak RidgesOntario). One of our Intake Workers will call the family to complete the Intake.

MARKHAM STOUFFVILLE HOSPITAL
CHILD DEVELOPMENT PROGRAMS

Parents may call directly to 1-888-703-5437 and make the referral over the telephone.