SURREY PLACE

2 Surrey Place,
Toronto ON M5S 2C2
416-925-5141
416-925-3402

# BLIND-LOW VISION EARLY INTERVENTION PROGRAM – REFERRAL / INTAKE FORM

☐ Consent received to send to the Toronto Blind-Low Vision Early Intervention

## Client Information

| | | | |
|---|---|---|---|
| **First Name:** | | | **Last Name:** |
| **Gender:** | ☐ Male | ☐ Female | **Date of Birth:** (yyyy/mm/dd) |
| **Service Language:** | ☐ English | ☐ French | ☐ Other: |
| **Interpreter Required** | ☐ Yes | ☐ No | |
| **Address:** | | | |
| **Parent/Guardian:** | | | |
| **Family Composition:** | | | |
| **Home Phone:** | | | **Other Phone:** |

## Vision Concerns / Reason for Referrals

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## Visual Impairment Diagnostic

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| **Rx** | ☐ Ophthalmologist<br>☐ Opometrist | **Name:** |

## Medical Diagnosis & Medication

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## Hearing Concerns

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## Growth & Development

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| **1. Speech/Language:** |
| **2. Gross Motor:** |
| **3. Fine Motor:** |

## Child's Daily Program

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| **☐ Childcare** | **☐ Nursery School/Drop-In** | **☐ Home** |
| **☐ School** | **☐ Rehab** | **☐ Inpatient** |
| **Name of childcare and/or school:** | | |
| **Contact Name:** | | |
| **Address:** | | |
| **Phone Number:** | | |

## Other Agencies Involved

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|---|---|
| **Name of Agency:** | |
| **Contact Person:** | **Phone Number:** |
| **Services Being Provided:** | |

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| **Name of Agency:** | |
| **Contact Person:** | **Phone Number:** |
| **Services Being Provided:** | |

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| **Name of Agency:** | |
| **Contact Person:** | **Phone Number:** |
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| **Services Being Provided:** | |

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| **Name of Agency:** | |
| **Contact Person:** | **Phone Number:** |
| **Services Being Provided:** | |

## Referral Source

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| ☐ **Please contact for initial joint visit** |
| **Name:** |
| **Agency:** |
| **Address:** |
| **Phone:** |