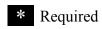
Vermont Association for the Blind & Visually Impaired

General Referral



Referring person:	
Agency:	Phone:
How did you hear about us?	
* Client name:	
* Mailing Address:	
* Physical Address (if different):	
* Temporary Location (ie. Rehab facility, Nursing home):	
County: Gender: \square M	Iale □Female D.O.B.
* Primary Home phone: S	econdary Home phone:
Emergency Contact:	Relationship:
Email address:	<u> </u>
Veteran □Yes □ No	
Cause of Vision Loss - if known	
	(-1:
□ Medicaid □ Other □ Medicaid/N □ Medicaid □ None □ Medicaid/O	
	Julei — Medicare/Other
Living with	
□ Alone □ Assisted Living (Private Residence) □ Assisted Living (Residential)	
□Not recorded □Other □Pers	onal Care Assistant □ Spouse
Type of Residence	
□Private Residence □Community Res	sidential
□ Nursing Home/Long Term Care □ Assisted Living □ Other	
Non-Vision impairment (choose no more than 5)	
□None □Mental (Cognitive, Psychosocial) □Dementia – short term □Dementia – long term	
☐ Cancer ☐ Musculoskeletal (Arthritis, Rheumatism, Amputee)	
☐ Cardiac/Circulatory ☐ Neuro. Impair. (Stroke, Neuropathy, Parkinson's, MS, CP, Seizures	
□ Diabetes Mellitus □ Respiratory or Lung conditions	
☐ Renal Disease/GI disorders ☐ Hearing	□Other □Client refused
Eye doctor:	□MD □OD Phone:
Address:	
Primary Care doctor:	Phone:
Address:	