2/12/19 website

Vermont Association for the Blind & Visually Impaired

General Referral

* Required

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: ☐ Male ☐Female	D.O.B.
* Primary Home phone:	Secondary Home phone:	
Emergency Contact:	Relationship:	

Email address:

Veteran ☐Yes ☐ No

Cause of Vision Loss - if known

Insurance

☐Medicaid ☐Other ☐Medicaid/Medicare ☐Medicaid/Medicare/Other
☐Medicare ☐None ☐Medicaid/Other ☐Medicare/Other

Living with

☐Alone ☐Assisted Living (Private Residence) ☐Assisted Living (Residential)
☐Not recorded ☐Other ☐Personal Care Assistant ☐Spouse

Type of Residence

☐Private Residence ☐Community Residential ☐Not Recorded
☐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:		

Client will be contacted by our intake specialist for additional information.

Andrea Hershberg • 60 Kimball Avenue • South Burlington VT 05403
800-639-5861 ext 214 • Fax 802-863-1481
ahershberg@vabvi.org