8/16/17

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
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