Department for Children and Families
Rehabilitation Services

LOW VISION REFERRAL
(to be completed by RS Staff)

Name: _____ Date: _____

Address: _____ Case Manager: _____

_____ Phone: _____

Telephone: _____ Send Report to the following address: _____
_____

DOB _____ SSN _____ _____

Others in household: _____

A. Vision History

Onset of vision loss: _____ Eye Doctor: _____
Cause of vision loss: _____ Last Eye Exam: _____
Recent vision changes: _____ What treatment: _____
Does vision fluctuate: _____ Surgery: _____
Eye pain: _____ Medication: _____
Laser: _____
Family history of eye problems: _____
_____

B. Medical History

General Health:

Medications:

C. Educational History (Vision problems in school?)

D. Vocational History (Occupation? Vision problems at work?)

E. Low Vision Goals (If we can make some visual task(s) easier, what would it be?)

_____ _____
Signature Date