7.1.19

Vermont Association for the Blind & Visually Impaired

General Referral

Referring person:	Phone:
Relationship to client:	
How did you hear about us?	
If you are from an agency please list below	
Agency:	Phone:
Client name:	
Mailing Address:	
Physical Address (if different):	
Temporary Location (Hospital, Rehab facility, Nursing home):	
Gender: ☐ Male ☐Female ☐Other	Date of birth:
Primary phone:	Secondary phone:
Email address:	
Veteran ☐Yes ☐ No	
Cause of Vision Loss (if known):	
Eye Care Provider (if known):	
Any additional impairments or comments:	

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

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ahershberg@vabvi.org