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| **ID-ASD-PD****CENTRALIZED ACCESS DESK****VISUAL IMPAIRMENT** |  |
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| **IDENTIFICATION OF THE CLIENT** |
| LAST NAME: |       | FIRST NAME: |       |
| Date of birth: |            | Gender: | F [ ]  M [ ]  |
| Health insurance number: |       | Expiry: |       |
| Address: |       | City:  |       | Postal code:       |
| Telephone: | Home:       | Cell:       | Work:       Ext.:      |
| Email: |       |
| Mode of communication: Telephone [ ]  TDD [ ]  | Legislation: AHSSS[ ] YPA [ ]  |
|  |
| **APPLICANT** |
| Professional’s name:       | Professional’s number:       |
| Telephone:       | Fax:       |
| Signature:       | Date:       | MD [ ]  OD [ ]  Date:       |
|  |
| **EYE HEALTH** |
| Date of last eye exam:       |
| Diagnosis OD |       |
| OS |       |
| Electrophysiological test results:       |
| Date of onset of visual impairment:       |
|  |
| Prognosis:       |
| Refraction OD:       |
|  OS:       |
|  | **OD** | **OS** | **OU** |
| Visual acuity (6 m) |       |       |       |
| With ophthalmological correction  |       |       |       |
| Intraocular pressure |       |       |  |

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| **PERIPHERAL FIELD OF VISION** |
| **premier oeil** | **premier oeil** |
| Target:       |

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| **RETURN THE FORM TO THE ID-ASD-PD CENTRALIZED ACCESS DESK**  |
| By mail: 1180, boulevard Manseau, Joliette (Québec), J6E 3G8By fax: 450-756-2898By email: guichet.ditsadp.cissslan@ssss.gouv.qc.caFor information: 1-877-322-2898 |