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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: AHSSSYPA | | | |
|  | | | | | | | | | | | | | | | | | | |
| **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 3G8  By fax: 450-756-2898  By email: [guichet.ditsadp.cissslan@ssss.gouv.qc.ca](mailto:guichet.ditsadp.cissslan@ssss.gouv.qc.ca)  For information: 1-877-322-2898 |