**Pre-Assessment Form**

Name:

Address:

Phone number Home: Cell:

Email address:

I am requesting this service for:

[ ]  Myself

[ ]  A patient

[ ]  A loved one

Date of birth:

Visual diagnosis:

Visual measurements (provide optometry/ophthalmology report, if available):

Other related/unrelated health conditions:

Indicate which type of training/service you would like to receive assistance with (mark all that apply):

|  |  |
| --- | --- |
| [ ]  Visual training | [ ]  Learning navigation technology |
| [ ]  Street crossings | [ ]  Orientation problems (getting lost) |
| [ ]  Public transportation (bus, metro, rail) | [ ]  Night travel |
| [ ]  Paratransit | [ ]  Winter travel |
| [ ]  Familiarization of a new environment (hospital, educational setting, moving, new employment) | [ ]  Cane skills |
| [ ]  Navigation of complex/unfamiliar environments (hospitals, malls, construction detours, etc.) | [ ]  Telescope training |

Difficulties encountered (be specific):

Have you previously seen an orientation and mobility specialist? [ ]  Yes [ ]  No

If so, when?

Current mobility aides used (if any):

Area(s) you would prefer to receive training sessions (mark all that apply). Please indicate the address beside the area marked if not already indicated above; otherwise indicate “neutral”:

[ ]  Place of residence

[ ]  Workplace

[ ]  Educational setting

[ ]  Commerce

[ ]  Public transit station

[ ]  Specific outdoor location

[ ]  Medical establishment

[ ]  Other

[ ]  Neutral

Individual(s) you would like to receive training with:

Relationship to yourself:

Preferred date(s) for service:

Preferred time of day [ ]  Morning [ ]  Afternoon [ ]  Evening

Preferred mode of communication [ ]  Phone [ ]  email [ ]  text

Where did you hear about our services?

[ ]  Internet search engine (Google, etc.)

[ ]  Social media (Facebook, Instagram, Twitter, etc.)

[ ]  Colleague

[ ]  Friend/family member

[ ]  Other

**Payment**

[ ]  Cheque [ ]  Cash [ ]  Credit card

[ ]  Visa [ ]  Mastercard [ ]  American Express

Name on card

Billing address

Card number

CVV

Expiration date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Please send the completed form to: clients@povsolutions.com