REFERRAL TO OLDER BLIND PROGRAM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
VOCATIONAL REHABILITATION
SFN 813 (10-2024)

			Date of Referral
Name		Gender ☐ Male ☐ Female	Date of Birth
Home Address	City	State	ZIP Code
Telephone Number	Email Address		
Etiology and Time of Onset of Vision Loss	Meets Criteria for Legal Blindness ☐ Yes ☐ No		
	Date Legal Blindness was Determined		
Comments			
Return Completed Form To	Name of Person Making Referral		
	Title		
	Telephone Number		