L.A.B. LOW VISION REHABILITATION CENTER
a division of Louisiana Association for the Blind

COMMUNITY SERVICES
1826 CLAIBORNE AVE.
SHREVEPORT, LA 71103
PHONE: 318.698.2300
FAX: 1.888.990.0751
WWW. LABLIND.COM

Please fill out the following documents:

1. Complete *the **Client information Form.*** **If you need assistance filling out this form, call us at (318) 698-2300**

2. Sign the "**Authorization to Disclose Information to family members and/ or friends**" form on any person that you allow L.A.B., LVRC to speak with regarding your Low Vision process.

3. Sign the "**Authorization to Release Medical Information**" form to receive your most recent eye medical records and a physician's order (Please provide eye physician's name).

4. Sign the "**Authorization to Disclose Protected Health Information**" form.

5. Copy of your **identification card** to verify proof of age is required.

6. Copy of Power of Attorney, if applicable.
   (If you are the personal representative and are signing these forms on behalf of the patient, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), a Designated Consent from a Regional Center Director or designee (pursuant to Welfare and institution's Code Section 4655), or other legal documentation showing you can sign for the individual must be attached to this form.)

7. Review the Community Assessment Program (CAP) fact sheet.

Please return above documents by one of the following:

Mail:

Attn: Kaleigh Malmay
1826 Claiborne Ave
Shreveport, LA 71103

Confidential Fax:

Attn: Kaleigh Malmay
1.888.990.0751

Scan & Email to: kmalmay@lablind.com

L.A.B./LVRC will contact you to schedule an initial low vision evaluation once we receive all required documents, including your eye medical records & physician's order. Please feel free to call 318-698-2300 with any questions.

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Client Information Form

All Client Information Is Required

Full Name: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

Social Security Number: _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Phone Number: _____ **Email Address:** _____

Alternate Contact Name: _____ **Phone:** _____

Emergency Contact Information:

- **Emergency Contact Name:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____

Are you a New Client: **Yes** **No**

Primary Care Physician:

- **Name:** _____
- **Phone Number:** _____
- **Address:** _____

Language Preferences:

- **Primary Language:** _____
- **Do you require an interpreter?** ☐ Yes ☐ No

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Race/Ethnicity:

- **Race:** (Check all that apply)
  - ☐ Asian
  - ☐ Black or African American
  - ☐ Hispanic or Latino
  - ☐ Native American or Alaska Native
  - ☐ Native Hawaiian or Other Pacific Islander
  - ☐ White
  - ☐ Other: _____
- **Ethnicity:** (Check one)
  - ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Marital Status:

- ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation:

- **Current Occupation:** _____

Additional Information:

- **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Mail
- Would you like more information about receiving appointment details and other updates via text or email?
  - ☐Yes ☐No

Type of Residence:

- ☐ Private Home/Apartment
- ☐ Senior Living/Retirement Community
- ☐ Assisted Living Facility
- ☐ Nursing Home/Long-Term Care Facility

Veteran Status:

1. **Are you a veteran?**
   - ☐ Yes ☐ No
   - Are you currently receiving care from any VA Services?
     - ☐ Yes ☐ No

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Referral Source:

- How did you hear about our services?
  - ☐ Physician
  - ☐ Eye Care Provider
  - ☐ Social Media
  - ☐ Community Event
  - ☐ Advertisement
  - ☐ Friend/Family
  - ☐ Internet Search
  - ☐ Other: _____

Medical History:

1. **Do you have a history of any of the following conditions?** (Check all that apply)
   - ☐ Diabetes
   - ☐ Stroke
   - ☐ Heart Problems
     - ☐ Heart Attack ☐ Angina ☐ Heart Failure ☐ Other: _____
   - ☐ High Blood Pressure
   - ☐ High Cholesterol
   - ☐ Respiratory Issues
     - ☐ Asthma ☐ COPD ☐ Other: _____
   - ☐ Kidney Problems
   - ☐ Liver Disease
   - ☐ Thyroid Problems
     - ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Other: _____
   - ☐ Gastrointestinal Issues
     - ☐ Ulcers ☐ IBS ☐ Other: _____
   - ☐ Neurological Conditions
     - ☐ Seizures ☐ Multiple Sclerosis ☐ Parkinson's ☐ Other: _____
   - ☐ Cancer
     - Specify type: _____ Year of Diagnosis: _____
   - ☐ Mental Health Conditions
     - ☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Other: _____

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2. **Primary Eye Condition:**
   - Diagnosis: _____
   - Date of Diagnosis: _____
3. **Last Eye Exam:**
   - Date of Last Eye Exam: _____
   - Provider Name: _____
4. **Other Eye Conditions:** (Check all that apply)
   ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration
   ☐ Diabetic Retinopathy ☐ Retinitis Pigmentosa ☐ Other:
5. **Current Medications:** (Please list all medications, vitamins, eye drops you are currently taking)
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
6. **Surgeries or Treatments:** (List any eye surgeries or treatments you've had)
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
7. **Family Medical History:**
   - **Do you have a family history of any of the following conditions?** (Check all that apply)
     - ☐ Diabetes ☐ Stroke
     - ☐ High Blood Pressure ☐ Cancer
     - ☐ Heart Problems ☐ Other: _____

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Vision Information:

1. **Do you use any visual aids or services?** (Check all that apply)

   ☐ Glasses/Contact Lenses ☐ Magnifiers ☐ Radio Reading Service

   ☐ Large Print Materials ☐ CCTV ☐ Other: _____

2. **Do you have difficulty with any of the following activities?** (Check all that apply)

   ☐ Reading ☐ Writing ☐ Financial Management

   ☐ Recognizing Faces ☐ Watching TV ☐ Cooking

   ☐ Eating ☐ Driving ☐Telling Time

   ☐Medication Management ☐ Shopping ☐ Glare

   ☐ Identifying money ☐Using the telephone

   ☐ Navigating in New Environments ☐Colliding with objects in your home

   ☐ Stepping off curbs and into the street ☐ Walking up or down stairs

   ☐Walking around your neighborhood ☐ Continuing with current occupation

   ☐ Other: _____

3. **Describe any specific vision-related difficulties you are experiencing:**

   - _____
   - _____
   - _____

Lifestyle and Goals:

1. **Daily Living Activities:**
   - Do you live alone? ☐ Yes ☐ No
   - Do you require assistance with daily activities? ☐ Yes ☐ No
   - If yes, please describe: _____
   - Do you have reliable transportation? ☐ Yes ☐ No

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2. **Occupation/School:**
   - Are you currently employed or in school? ☐ Yes ☐ No
   - If yes, what is your occupation or field of study? _____

---

3. **Hobbies and Interests:**
   - Please list any hobbies or activities you enjoy: _____
   - _____

---

4. **Goals for Low Vision Services:**
   - What are your primary goals from seeking our services? _____

Substance Use:

1. **Tobacco Use:**
   - Do you currently use tobacco products/vapes/E-Cigarettes?
     - ☐ Yes
     - ☐ No
   - If yes, please specify the type and frequency:
     - Type: _____
     - Frequency: _____
   - Are you a former tobacco user?
     - ☐ Yes
     - ☐ No
   - If yes, when did you quit? _____
2. **Recreational Drug Use:**
   - Do you use any recreational drugs?
     - ☐ Yes
     - ☐ No
   - If yes, please specify the type and frequency:
     - Type: _____
     - Frequency: _____
3. **Alcohol Use:**

- How often do you consume alcohol?
  - ☐ Never ☐ Occasionally/Socially ☐ Monthly ☐ Weekly ☐ Daily

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Additional Information:

- Is there any other information you feel is important for us to know?

_____
_____
_____

Additional Questions:

1. **What activity is most frustrating to you since your vision has decreased?**
   - _____
   - _____
2. **Are you considering moving into an assisted care facility or with family members because of your vision? (Please Specify)**
   - _____
   - _____
3. **Do you need support and/or assistance in adjusting to your vision loss?**
   - ☐ Yes
   - ☐ No
4. **Do you currently use a computer, cell phone/tablet?**
   - ☐ Yes
   - ☐ No
5. **Have you received any low vision rehabilitation services from any other agency or program? (Please Specify)**

   _____
6. **Have you ever had a previous low-vision evaluation?**
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - If yes, when and where? _____

_____

7. **Have you tried anything to help with your vision?**
   - ☐ Yes
   - ☐ No
   - If yes, what have you tried and was it helpful?
   - _____
     _____

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If this form is being completed by someone other than the patient:

- **Name of Person Completing This Report:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____
- **Date:** _____

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Authorization to Release Medical Information

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that L.A.B., LVRC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law. **If this form is not completed, as applicable, Louisiana Association for the Blind will be unable to process your request. Incomplete authorization requests will be returned.**

I,_____, [Insert Name of Patient/Client], WHOSE DATE OF BIRTH IS _/__ /___HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM MY RECORDS.

THE FOLLOWING OPHTHALMOLOGIST/OPTOMETERIST/FACILITY IS AUTHORIZED TO USE, RELEASE, OR DISCLOSE THE HEALTH INFORMATION:

Ophthalmologist/Optometrist/Clinic:	
Address:	
Citv /State:	**Zip Code:**

NAME OF THE PERSON/FACILITY I AUTHORIZE TO RECEIVE THE HEALTH INFORMATION:

Name: L.A.B. Low Vision Rehabilitation Center	**Phone: (318) 698-2300**
Address: 1826 Claiborne Avenue	**Fax: 1-888-990-0751**
Citv: Shreveport State: LA	**Zip Code: 71103**

DESCRIPTION OF SPECIFIC INFORMATION TO BE RELEASED:

Most current eye exam including diagnosis, visual acuity & fields, and contrast sensitivity
Physician's order/Rx: Low Vision Evaluation, OT Evaluation, and Treatment

THE ABOVE LISTED INFORMATION IS TO BE RELEASED FOR THE SPECIFIC PURPOSES OF:

Evaluation and services provided at the Low Vision Rehabilitation Center

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
I understand that my permission to release this information may be cancelled at any time except when the information has already been released. My permission to release this information will expire:___/_____/_____.
I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

X _____ _____

Signature **Date**

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Authorization to Disclose Protected Health Information

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that L.A.B., LVRC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law. **If this form is not completed, as applicable, Louisiana Association for the Blind will be unable to process your request. Incomplete authorization requests will be returned.**

I,_____, [Insert Name of Patient/Client], WHOSE DATE OF BIRTH IS _/ / HEREBY VOLUNTARILY AUTHORIZE THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM MY RECORDS.

THE FOLLOWING PERSON/FACILITY IS AUTHORIZED TO USE, RELEASE, AND/OR DISCLOSE THE HEALTH INFORMATION:

Name: L.A.B., Low Vision Rehabilitation Center		
Address: 1826 Claiborne Avenue		
City: Shreveport	**State: LA**	**Zip Code: 71103**

NAME OF THE PERSON/FACILITY I AUTHORIZE TO RECEIVE THE HEALTH INFORMATION:

Name: Louisiana Workforce Commission		**Phone: (225) 219-2943**
Address: 950 N. 22nd Street		
City: Baton Rouge	**State: LA**	**Zip Code: 70802**

DESCRIPTION OF SPECIFIC INFORMATION TO BE RELEASED:

Contact information
Low Vision Evaluation and vision aids provided at the Low Vision Rehabilitation Center
Assistive device consultation, instruction, and follow- up

THE ABOVE LISTED INFORMATION IS TO BE RELEASED FOR THE SPECIFIC PURPOSES OF:

Reporting and budgeting purposes for services provided at the Low Vision Rehabilitation Center

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
I understand that my permission to release this information may be cancelled at any time except when the information has already been released. My permission to release this information will expire:___/____/_____.
I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

X _____ _____

Signature **Date**

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SHREVEPORT, LA 71103
318.698.2300
FAX: 318.698.2304
CONFIDENTIAL FAX: 1.888.990.0751
WWW .LABLIND.COM

Authorization for Communication Between Client and LVRC

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that L.A.B., LVRC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law. **If this form is not completed, as applicable, Louisiana Association for the Blind will be unable to process your request. Incomplete authorization requests will be returned.**

I,_____, client of Louisiana Rehabilitation Services (LRS), WHOSE DATE OF BIRTH IS _/__ /_____HEREBY AUTHORIZE L.A.B.'s LVRC TO DISCUSS RESULTS OF EVALUATIONS, RECOMMENDATIONS AND MEDICAL RECORDS WITH ME AS IT PERTAINS TO MY INSTRUCTIONAL TRAINING.

THE FOLLOWING CLIENT AUTHORIZES RELEASE OR DISCLOSURE OF HEALTH INFORMATION:

Name:	
Address:	
Citv /State:	**Zip Code:**

NAME OF THE FACILITY I AUTHORIZE TO USE, RELEASE, OR DISCLOSE THE HEALTH INFORMATION TO THE CLIENT LISTED ABOVE:

Name: L.A.B. Low Vision Rehabilitation Center		**Phone: (318) 698-2300**
Address: 1826 **Claiborne Avenue**		**Fax: 1-888-990-0751**
Citv: Shreveport	**State: LA**	**Zip Code: 71103**

DESCRIPTION OF SPECIFIC INFORMATION TO BE RELEASED:

Comprehensive evaluation	
Low Vision Evaluations/Recommendations	
Medical Records	

THE ABOVE LISTED INFORMATION IS TO BE RELEASED FOR THE SPECIFIC PURPOSES OF:
Evaluation and services provided at the Low Vision Rehabilitation Center

I understand that my permission to release this information may be cancelled at any time except when the information has already been released. I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. My permission to release this information will expire:____/____/_____. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

X _____ _____

Signature **Date**

Client Assistance Program

CAP

Statewide assistance to consumers or applicants of Louisiana Rehabilitation Services (LRS) and American Indian Rehabilitation Services (AIRS) in securing rights guaranteed by the Rehabilitation Act

What is the Client Assistance Program?

The Client Assistance Program (CAP) helps Louisiana Rehabilitation Services (LRS) and American Indian Rehabilitation Services (AIRS) consumers and applicants to understand all their benefits and rights under the Rehabilitation Act of 1973.

When appropriate, and the issue is worthy CAP may assist consumers and applicants in pursuing legal, administrative or other appropriate ways to protect their rights.

Your Rights as a consumer of LRS and AIRS are to:

- a fair and complete evaluation to determine eligibility;
- know why you may be considered ineligible for services;
- be a partner in planning the goals and services of your rehabilitation program;
- prompt, equitable and adequate services;
- confidentiality of records; and
- an appeals process.

You may be eligible for CAP assistance if you:

- have applied for LRS/AIRS services;
- are receiving LRS/AIRS services;
- have been determined ineligible for LRS/AIRS services;
- find that your LRS/AIRS program has been changed or stopped without your consent;
- are dissatisfied with the services you are receiving, or have been denied certain services;
- are experiencing problems with projects, programs and facilities providing services to you under the Rehabilitation Act; or
- are a parent, guardian or other advocate who is seeking assistance for a person who is eligible.

CAP can help:

- explain LRS and/or AIRS processes and clarify the rules, regulations, and procedures of the programs and how they affect you;
- describe projects, programs and facilities providing services under the Rehabilitation Act;
- advise you and service providers about ways to resolve problems that interfere with the rehabilitation process and delivery of services;
- assist you, when appropriate, in taking the administrative and legal steps necessary to protect your rights;
- assist the LRS and/or AIRS agency in identifying and removing program barriers; and
- refer you to other resources for services, if applicable.

How can you receive CAP services?

Call or write the CAP office for information and/or assistance, see below:

Advocacy Center
8325 Oak Street
New Orleans, LA 70118
(504) 522-2337 V/TDD
Toll-free 1-800-960-7705 V/TDD
E-Mail: http:\\www.advocacyla.org

All services of CAP are confidential, free of charge, and provided without regard to race, creed, color, sex, age, national origin, or disability.