867 Thompson Dr S, Thompson MB R8N1Z4
Phone: 204-677-5333 Fax 204-778-1741

MANITOBA RETINAL SCREENING VISION PROGRAM (MRSVP)

Client Information:

Name: _____ Address: _____

DOB: _____ Community: _____

PHIN: _____ Gender: Male ☐ Female ☐ Non-binary ☐

Client's Primary Physician: _____ Phone #: ( ) _____-_____

Client's Preferred Language: _____

****Type of Diabetes**

☐ Type 1 ☐ Type 2 ☐ Pre-existing diabetes and pregnancy **Dx Year**: _____

** Please note, only clients with these diagnoses qualify to be seen by MRSVP. Referrals for clients with Prediabetes or other ocular conditions should be referred to an optometrist for a dilated eye exam if deemed necessary.

Ocular History	
Has the client ever been referred to an ophthalmologist?	☐ Yes ☐ No
Has the client ever been diagnosed with Retinopathy?	☐ Yes ☐ No
Has the client had recent changes in vision?	☐ Yes ☐ No

Lab Tests	Standard Value	Results	Date
Glycated Hemoglobin (HbA1C) (Q3 months)	<7.0 %		

Other pertinent information: _____

_____

_____

_____

_____

Name of person completing: _____ **Date:** _____

Fax to 204-778-1741 once complete