The Iris Network Rehabilitation Center
Client Application Form

Client Contact Information

Name: Date of Birth:
Street Address:
City: State: Zip Code:

Telephone #: Email:

Preferred mode of communication (e.g. large print, e-mail, mail, braille, phone or audio):

Emergency Contact Information

Emergency Contact Name: Relationship:
Street Address:
City: State: Zip Code:

Telephone #: Email:

Health Information

Please attach a copy of your insurance card (front and back) and a list of all medications.

Cause of vision loss:
Onset of vision loss:
If you have a legal blindness diagnosis, when was it diagnosed?
Name of eye doctor:
Eye doctor telephone number:
Name of primary care physician:
Primary care physician telephone number:
Name of health insurance company (required):
Health insurance ID number (required):
Social Security Number:
Are you your own guardian? (If no, please attach copy of guardianship decree.)

The Iris Network Rehabilitation Center
Client Application Form

Please list all health diagnoses:

Please list any medications:

Please list any allergies:

Please list any dietary restrictions:

Vision Aids

Please list any mobility aids you use:

Please list any vision aids you use:

Please list the access technology you use:

Please list any medical assistive devices you use:

Tell Us About Yourself

Briefly describe your work experience:

Briefly describe any volunteer experience:

What hobbies or interests do you have?

What languages do you speak at home?
What level of education have you completed?

The Iris Network Rehabilitation Center
Client Application Form

Briefly describe your current living arrangement, for example, alone, with spouse, with family, with significant other, other.

What are three goals you would set for yourself if admitted to the program?

Is there anything else you would like us to know?

Printed Name:

Signature:

Date: