Center of Vision Enhancement (COVE)
Initial Contact Form

Name _____ **Date** _____

Address _____

City _____ , CA **Zip** _____

Type of Residence:
☐ Private Residence ☐ Senior Living Complex ☐ Assistive Living Facility
☐ Nursing Home ☐ Homeless

Phone _____ **Other Contact Phone:** _____

Email address _____

Date of Birth: _____ or age range: _____

Gender: ☐ Male ☐ Female ☐ Did not disclose

Preferred Language, if other than English: _____

Vision Status:
☐ **Sighted** ☐ **Low Vision** ☐ **Legally Blind** ☐ **Totally Blind**

Race/Ethnicity (choose all that apply)

☐ American Indian or Alaska Native	☐ White
☐ Asian	☐ Hispanic / Latino
☐ Black / African-American	☐ Did not disclose
☐ Hawaiian or Pacific Islander	☐ Other:

Cause of Visual Impairment _____

Other Health Concern or Impairment ☐ no ☐ yes (complete reverse side)

How did you hear about us?

☐ Eye Care Provider	☐ VA-Veteran's Admin	☐ Website or Media
☐ Doctor's Office	☐ Indep Living Center	☐ Faith-Based Org
☐ DOR-Dept of Rehab	☐ Senior Program	☐ School
☐ Social Services	☐ Family or Friend	☐ Self-Referral

Other: _____

COVID-19 Vaccine? ☐ yes ☐ no ☐ prefer not to answer

I give permission for COVE to contact the following entities on my behalf:
☐ Department of Rehabilitation ☐ School: _____
☐ Veteran's Administration ☐ Other: _____
☐ Independent Living Center

☐ I would like to be included on the COVE mailing list.

I understand that the above information will not be shared without my permission.

Signature: _____ Date: _____

Other Health Concern or Impairment

- ☐ Hearing Impairment
- ☐ Mobility Impairment
- ☐ Communication Impairment
- ☐ Cognitive or Intellectual Impairment
- ☐ Mental Health Impairment
- ☐ Other Impairment: _____