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: ____