

**Professional Referral Form**

**Fields marked with an asterisk (\*) are compulsory**

| **Client Details** | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title\*** | | Choose a Title | | | | **Date of Birth\*** | | | dd/mm/yyyy | | |
| **First Name\*** | | Enter your First Name | | | | | | | | | |
| **Last Name\*** | | Enter your Last Name | | | | | | | | | |
| **What best describes your gender?** | | | | | | | | | | | |
|  | Male | | |  | Female | | |  | Prefer not to say | | |
|  | Prefer to self-describe: Enter text here. | | | | | | | | | | |
| **Address\*** | | First Line of Address  Second Line of Address  Town  County  Postcode | | | | **Living situation** | | | | | |
|  | Alone | | |  | With family |
|  | Care Home | | |  | Not known |
|  | Sheltered accommodation | | | | |
| **Contact No.\*** | | Home | Enter number | | | | Mobile | | | Enter number | |
| **Preferred method of contact\*** | | | Choose a contact method. | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ocular History** | | | | | | | | |
| **Eye condition\*** | Add eye condition here | | | | | | | |
| **Registered\*** |  | Severely sight impaired |  | Sight impaired |  | Not Registered |  | Not known |

|  |  |  |
| --- | --- | --- |
| **General Health** | | |
| **General health and other disabilities** | Click or tap here to enter text. | Hearing impairment |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sight Support Services**  **All service users will be offered a needs assessment, but if you would like to alert us to any areas of specific need, please use the following:** | | | | | |
|  | Communication |  | Technology |  | Managing at home |
|  | Moving around |  | Meeting Others |  | Pursuing interests |
|  | Finances |  | Employment |  | News and events |
|  | Other (please specify below):  Add additional needs you want to highlight here. | | | | |

|  |
| --- |
| **Any further information (optional)** |
| Add additional information here |

|  |  |
| --- | --- |
| **Disclosure of Information and Confidentiality Agreement\*** | |
| All personal information provided by you will be treated strictly in terms of the Data Protection Act 2018. When we ask you for specific details, we’ll always be clear about why we need them and make sure that your personal information is kept secure. We will not sell your details to any third parties for marketing purposes. We will seek your permission if we need to share your information to make referrals with trusted health and statutory organisations, such as social services and NHS health providers. | |
| **Client Signature** |  |
| **Date** | Click or tap to enter a date |
| If client not present, please tick box to indicate verbal consent given | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
| **How did you hear about us?** | | Click or tap here to enter text. | |
| **Name\*** | Add First and Last name here. | | **Organisation details\***  Organisation name  1st Line of Address  2nd Line of Address  Town  County  Postcode  Telephone number |
| **Position\*** | Add job title | |
| **Tel. Number\*** | Add telephone number here | |
| **Email** | Add email address here | |
| **Signed\*** | Add Electronic Signature here  Emailed copies will be considered as signed electronically | | |
| **Date\*** | Click or tap to enter a date | | |

Please post completed form to Sight Support West of England, The Vassall Centre, Gill Ave, Bristol, BS16 2QQ. Or email to [info@sightsupportwest.org.uk](mailto:info@isightcornwall.org.uk) – mark subject of email as ‘Service Referral – Confidential’