

**Professional Referral Form**

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | | | | |
| **Title\*** | |  | | | | **Date of Birth\*** | | |  | |
| **First Name\*** | |  | | | | | | | | |
| **Last Name\*** | |  | | | | | | | | |
| **What best describes your gender?** | | | | | | | | | | |
|  | Male | |  | | Female |  | Prefer not to say | | | |
|  | Prefer to self describe: | | | | | | | | | |
| **Address\*** | |  | | | | **Living situation** | | | | |
|  | Alone |  | | With family |
|  | Care Home |  | | Not known |
|  | Sheltered accommodation | | | |
| **Contact No.\*** | | Home | |  | | | Mobile |  | | |
| **Preferred method of contact\*** | | | |  | | | | | | |

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

|  |  |  |
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| **General Health** | | |
| **General health and other disabilities** |  | Hearing impairment |

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| **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): | | | | |

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| **Any further information (optional)** |
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| **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** |  |
| If client not present, please tick box to indicate verbal consent given | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
| **How did you hear about us?** | |  | |
| **Name\*** |  | | **Organisation details\*** |
| **Position\*** |  | |
| **Tel. Number\*** |  | |
| **Email** |  | |
| **Signed\*** | Emailed copies will be considered as signed electronically | | |
| **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’