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|  |  |
|  |  |
|  | Date |



**REFERRAL FOR LOW VISION ASSESSMENT**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name\* |  | | | |
| Address\* |  | | | |
|  |  | | | |
| Contact No\* | Home: | | Mobile: | |
| Email: |  | | | |
| NHS Number\* |  | | Date of Birth\* | |
| Living situation\* | Alone | With partner / spouse | With other relative | Residential Care |
| GP Practice\*  Name, Address, Tel |  | | | |
| General Health and other disabilities |  | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sight Loss Eye Condition (please tick)\* | | | | | | | | | |
| **R** | **L** |  | | | **R** | **L** | |  | |
|  |  | ARMD (Dry) | | |  |  | | Hemianopia | |
|  |  | ARMD (Wet) | | |  |  | | Myopic Degeneration | |
|  |  | Cataracts | | |  |  | | Keratoconus | |
|  |  | Charles Bonnet | | |  |  | | Nystagmus | |
|  |  | Diabetic Retinopathy | | |  |  | | Retinal Detachment | |
|  |  | Glaucoma | | |  |  | | Retinitis Pigmentosa | |
|  | | | | | | | | | |
| If other, please specify: | | |  | | | | | | |
| Date of last visit to Optometrist: | | |  | | | | | | |
| Registered\*  CVI | | | SSI | SI | | | Not registered | | Unknown |
| Difficulties\* (Reading, writing, cooking, television, glare) | | |  | | | | | | |
| Is the patient available at short notice? Yes / No | | | | | | | | | |
| Have you had a previous Low Vision Assessment in Somerset? | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Other services of interest: | Technology support | Clubs / Activities | Eye clinic support | Everyday living / benefit support |
| Any other information: |  | | | |

|  |
| --- |
| **Client Signature**  Signed ..................................................................................................................  Date ........................................................  If client not present, please tick box to indicate verbal consent given. |
| **Referrer Details**  **Signed\*** ........................................................................................................................  Print Name\* ...................................................................Date ........................................  Practice Name\* ...............................................................................................................  Full Address\*....................................................................................................................  Tel\*........................................................ Email ................................................................ |