Somerset Sight
Working with people who lack sight, not vision

REFERRAL FOR LOW VISION ASSESSMENT

Date

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:	

Please post completed form to: Somerset Sight, Northfield House, Staplegrove Road, Taunton, TA1 1DG.
Or email to: somicb.lvasomersetsight@nhs.net mark subject of email: Low Vision Referral Confidential.

Registered* CVI	SSI	SI	Not registered	Unknown
Difficulties* (Reading, writing, cooking, television, glare)				
Is the patient available at short notice? Yes / No				

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 .....

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