iSightCornwall®

Referral Type:
- ☐ Routine (low risk)
- ☐ Urgent (moderate risk)
- ☐ Emergency (critical risk)

Fields marked with an asterisk (*) are compulsory.

Client Details				
Title*		**Gender**	☐ Female ☐ Male	
Surname*		**Forename(s)***		
Address* (incl. postcode)	Postcode:	**Living situation** ☐ Alone ☐ Residential Care ☐ With partner/spouse ☐ Sheltered accomm. ☐ With other relative ☐ Not known		
Contact No.*	Home:	Mobile:		
Preferred method of contact*				
Date of Birth*		**NHS Number**		

Ocular History			
Eye condition*			
Name of Consultant		**Date of last appt**	
Name of Optician		**Date of last appt**	
Registered*	☐ Severely sight impaired ☐ Sight impaired ☐ Not Registered ☐ Unknown		

General Health		
GP Practice*		
General health and other disabilities	☐ Hearing impairment	
Risk assessment carried out?*	☐ Yes ☐ No	If yes, please provide further details:

iSightCornwall services required		
☐ Technology and gadgets at home	☐ Social activities	☐ Eye Clinic Support
☐ Advice and guidance	☐ Everyday living aids	☐ Other
☐ Low Vision (please note that for a referral to this service you will need to fill out either the eye consultant or optician details above. The client must have been seen within the last 12 months)		

Reason for referral

e.g. tasks the patient finds difficult / any low vision aids the patient currently uses / support that the patient is seeking

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*		
Contact Number*		
Email		
Signed*		
Date*		

Please post completed form to iSightCornwall, The Sight Centre, Newham Road, Truro, TR1 2DP. Or email to lowvision@isightcornwall.org.uk – mark subject of email as 'Service Referral – Confidential'