|  |
| --- |
| Referral Type: |
| [ ]  | Routine (low risk) |
| [ ]  | Urgent (moderate risk) |
| [ ]  | Emergency (critical risk) |



**Healthcare Professional Referral Form**

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

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

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| --- |
| **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 |

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| **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** |
| [ ]  | Assistive Technology | [ ]  | Clubs and Activities | [ ]  | Everyday Living |
| [ ]  | Benefits Advice | [ ]  | Employment Support | [ ]  | Eye Clinic Support |
| [ ]  | 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 client finds difficult / any low vision aids the client currently uses |
| **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 info@isightcornwall.org.uk – mark subject of email as ‘Service Referral – Confidential’