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

**Low Vision Clinic Referral**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Title\*** | | | |  | | | | | | | | **Gender** | | | | | | | |  | | | Female | | | | | | | |  | | | Male | | | | |  | | | | | |
| **Surname\*** | | | |  | | | | | | | | | | | | | | | | **Forename(s)\*** | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Address\*  (incl. postcode)** | | | |  | | | | | | | | | | | | | | | | | **Living situation** | | | | | | | | | | | | | | | | | | | | | | | |
| ☐ | | | Alone | | | | | | | | | | | | | | ☐ | | Residential care | | | | |
| ☐ | | | Partner/spouse | | | | | | | | | | | | | | ☐ | | Sheltered accomm. | | | | |
| Postcode: | | | | | | | | | | | | | | | | | ☐ | | | With other relative | | | | | | | | | | | | | | ☐ | | Not known | | | | |
| **Contact No.\*** | | | | Home: | |  | | | | | | | | | | | | | | | | | | | | Mobile: | | | | | | |  | | | | | | | | | | | |
| **Date of Birth\*** | | | |  | | | | | | | **NHS Number** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Ocular history** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Registered\*** | | ☐ | | Severely sight impaired | | | | | | | | | | | | ☐ | | Sight impaired | | | | | | | | | | ☐ | | Not Registered | | | | | | | | | | | ☐ | | Not known | |
| **Sight loss condition\***  Other (please specify): | | | | | | | | | **R** | | **L** | | |  | | | | | | | | | | | | | | | **R** | | | | | **L** |  | | | | | | | | | |
|  | |  | | | ARMD (dry) | | | | | | | | | | | | | | | ☐ | | | | |  | Hemianopia | | | | | | | | | |
|  | |  | | | ARMD (wet) | | | | | | | | | | | | | | | ☐ | | | | |  | Keratoconus | | | | | | | | | |
|  | |  | | | Cataracts | | | | | | | | | | | | | | | ☐ | | | | |  | Myopic Degeneration | | | | | | | | | |
|  | |  | | | Charles Bonnet | | | | | | | | | | | | | | | ☐ | | | | |  | Nystagmus | | | | | | | | | |
|  | |  | | | Diabetic Retinopathy | | | | | | | | | | | | | | | ☐ | | | | |  | Retinal Detachment | | | | | | | | | |
|  | |  | | | Glaucoma | | | | | | | | | | | | | | | ☐ | | | | |  | Retinitis Pigmentosa | | | | | | | | | |
| **Date of last eye examination\*** | | | | | | | |  | | | | | | | | | | | **Best Binocular Vision** | | | | | | | | | | | | | | | Distance | | | | | | | | | Near | |
| **Visual Acuities\* (Current Vision or VA with spectacles)** | | | | |  | | VA | | | Sph | | | | | | | Cyl | | | | | Axis | | | | | VA | | | | | Prism | | | | | Base | | | | | Add | | VA |
| RE | |  | | |  | | | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | |  |
| LE | |  | | |  | | | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | |  |
| **Other relevant investigations and/or treatments** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GP Practice\*** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General health and other disabilities** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hearing impairment | | | | | | | | |
| **Reported difficulties\* (tick all that apply)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Reading | | | | | | | | | |  | | | | Cooking | | | | | | | | | | | | | | | |  | | | Telling time | | | | | | | | | | |
|  | Writing | | | | | | | | | |  | | | | Television | | | | | | | | | | | | | | | |  | | | Glare | | | | | | | | | | |
|  | Taking medication | | | | | | | | | |  | | | | Landline telephone | | | | | | | | | | | | | | | |  | | | Lighting | | | | | | | | | | |
|  | Shopping | | | | | | | | | |  | | | | Crafts | | | | | | | | | | | | | | | |  | | | Using mobile or computer | | | | | | | | | | |
| **Help most needed with** | | | | | | | | | 1.  2.  3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Low Vision Clinic(s)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Wadebridge (once a month) | | | | | | | | | |  | | Penzance (once a month) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Helston (once a month) | | | | | | | | | |  | | St Austell (twice a month) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Falmouth (every 6-8 weeks) | | | | | | | | | |  | | Truro (weekly) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Redruth (once a month) | | | | | | | | | |  | | Home visit – *(by exception only - £25 charge for travel)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other iSightCornwall services required** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Technology and gadgets at home | | | | | | | | | |  | | | | Social activities | | | | | | | | | | | | | | | |  | | | Everyday living aids | | | | | | | | | | |
|  | Advice and guidance | | | | | | | | | |  | | | | Eye clinic support | | | | | | | | | | | | | | | |  | | | Employment support | | | | | | | | | | |
| **Any other information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e.g. 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**  Signed ………………………………….…………………………...........................  Date ………………………………………………….  If client not present please tick box to indicate verbal consent given | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Optometrist Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signed\*** | | |  | | | | | | | | | | | | | | | | | | | **Practice details\*** | | | | | | | | | | | | | | | | | | | | | | |
| **Name\***  **(please print)** | | |  | | | | | | | | | | | | | | | | | | |
| **Date\*** | | |  | | | | | | | | | | | | | | | | | | |

**Please email to** [**lowvision@isightcornwall.org.uk**](mailto:lowvision@isightcornwall.org.uk)