

**CONFIDENTIAL**

|  |  |
| --- | --- |
| **Name of the service user :** |  |
| **Date of birth :** |  |
| **Address and contact number :** |  |
| **Eye condition:** |  |
| **Registration category: SI/SSI:** |  |
| **Reason for referral :** |  |
| **Other agencies known to be involved with the service user** |  |
| **Any known risks or potential risks relating to the service user or any member of their household that lone workers should be aware of** |  |
| **Additional information:** |  |
| **Name, organisation and contact details of referrer:** |  |
| **Date of referral :** |  |
| **Consent given by client to make referral :** | **Yes / No**  **If no, why not ……………………………………….** |

**Please send to:**

[**referrals@berkshirevision.org.uk**](mailto:referrals@berkshirevision.org.uk)

**Berkshire Vision**

**Midleton House, 5 Erleigh Road**

**Reading**

**RG1 5LR**

**Tel. 0118 9872803**