

**CONFIDENTIAL**

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| **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**

**Berkshire Vision**

**Midleton House, 5 Erleigh Road**

**Reading**

**RG1 5LR**

**Tel. 0118 9872803**