

**Vision Support External Referral Form**

**Please note: Essential referral information required is marked with an \***

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| **Client Details** |
| Referral Date \* (Date referral sent)  |  |
| Title and Name\*:  |  |
| Address/County\* |  |
| Telephone No\*:  |  |
| Email:  |  |
| DOB: \* |  |
| Eye Condition |  |
| Registration Status (if known)  | Sight Impaired (SI) | Severely Sight Impaired (SSI) | Not Registered  |
| Consent Gained\* | Yes  | No |
| Any known risk\* | Yes (*please provide details)* | No  |
| Who does the client live with? \* |  |  |
| Other agencies involved |  |
| Is this client in receipt of any benefits?  | *(If yes please state here)*  |
| **Please tick service**  |
| **Home Visitor** | **Welfare rights** | **Digital Skills** |
| **Social Groups** |  | **Telephone Befriending** |
| **Referrer Details** |
| Name: \* |  |
| Email: \* |  |
| Organisation: \* |  |
| **Reason for Referral** |
|  |

**Thank you for your referral. Please send to** **referrals@visionsupport.org.uk**