

**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**](mailto:referrals@visionsupport.org.uk)