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)	Postcode:	**Living situation** ☐ Alone ☐ With partner/spouse ☐ With other relative	☐ Residential Care ☐ Sheltered accomm ☐ 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*	R	L		R	L	
Other (please specify):	☐	☐	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	☐ Telephone	☐ Lighting
☐ Shopping	☐ Crafts	☐ Using Computer

Help most needed with

1.
2.
3.

Preferred Low Vision Clinic(s)

☐ Wadebridge (once a	☐ Penzance (once a month)
☐ Helston (once a month)	☐ St Austell (twice a month)
☐ Launceston (every 6-8	☐ Truro (weekly)
	☐ Home Visit *Please note there is a £20 charge for home visits*

Other iSightCornwall services required

☐ Assistive Technology	☐ Clubs and Activities	☐ Everyday Living
☐ Benefits Advice	☐ Employment	☐ Eye Clinic 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	
Date*	

Please post completed form to iSightCornwall, The Sight Centre, Newham Road, Truro, TR1 2DP. Or email to info@isightcornwall.org.uk – mark subject of email as ‘Low Vision Referral – Confidential’