

**Referral Form**

**Clients Details**

Title:

First Name:

Surname:

Preferred to be known as:

Address Line 1:

Address Line 2:

Address Line 3:

Town:

County:

Postcode:

Landline Phone No:

Mobile Phone No:

Additional No(s):

Email address:

Preferred Format to receive Information (Please mark X next to chosen format)

* Large Print
* Email
* Braille
* Audio

Date of Birth:

Gender:

Ethnicity:

**Sight and Medical**

Registration Status:

* Sight Impaired / Partially Sighted
* Severely Sight Impaired / Blind
* Not Registered
* Unknown / Not Sure

Hospital Attending:

Eye Conditions:

* Macular Degeneration – Wet / Dry
* Dry Eye
* Glaucoma
* Retinitis Pigmentosa (RP)
* Nystagmus
* Retinal Detachment
* Diabetic Retinopathy
* Other (please specify):

Guide Dog User (Guide Dog Name):

Additional Health & Communications Issues: e.g. Dementia, Hearing Loss

Domestic Information: Lives alone, Lives with family, Lives with partner

Any existing care package information:

Other referrals made (Fire Service, DWP, Low Vision):

Safeguarding (Any known areas of risk for staff/volunteers):

**Next of Kin Details**

Name:

Phone Number:

Email:

Relationship to client:

Are they a keyholder?:

Please complete the GDPR sections. If these sections are not completed the referral form will be returned to you.

**GDPR Permissions – Please respond with YES or NO**

* Store your information on our database
* Send you general information on our work
* Can we contact you be telephone?
* Can we contact you by email?
* Can we contact you in writing?

I understand that I will not be contacted again regarding consent to be on the database and that I will contact My Sight Notts if I wish my details to be removed.

Please return your completed forms to **referrals@mysightnotts.org.uk**