| Title: | Address: |
| --- | --- |
| Full Name: |  |
| Date of Birth: |  |
| Gender:  Male/ female/ other |  |
| NHS Number: | Area: |
| Ethnic Origin: | Telephone: |
| Marital Status: | Alternative telephone: |
| Where did you hear about us? | Eye Condition: |
| Not Registered  Registered Partially Sighted (SI)  Registered Blind (SSI) | Speech Impairment Yes  No  Hearing Impairment Yes  No |
| Eye Hospital or clinic | Consultant name |
| Does client require an interpreter to be present? If Yes what is required language.  Yes  No | |
| Mobility aid used?  Walker  Wheelchair  Walking stick  Long cane | |
| Any history of falls: | |
| General Health/ Disabilities | |
| **Service required**  Mobility Assessment  Home assessment  Eye Talk Programme  Lighting assessment  Other: please state  At Clients home  or Office Support Clinic | |
| Why is service required? | |
| Client lives alone Yes  No  Receive any support from Family or friends Yes  No | |
| Preferred method of communication:  Large Print  Email  Telephone | |
|  | |
| **Referral completed by:**  **Referral organisation:**  **Referral contact number:** | |
| *This information will be stored on our database and will be passed to Adult Care Services and other third party agencies that may be able to help provide services for you.*  *Please sign and date your acceptance of these conditions.* | |
| Client aware of referral:  Yes  No  Consent given:  Yes  No  Date of referral: | |