Visual Impairment Team Referral

Please complete as many details on this form as necessary, this will help us to set the correct priority to the referral.

Client Details			
Full Name			
Full Address (include Post Code)			
Telephone Number			
Email Address Client			
Date of Birth		**Gender**	☐ Male ☐ Female
Does Client agree to the referral	YES ☐ NO ☐ If No, please specify why: Permission must be given by the Client unless they are unable to do so before an Assessment can go ahead.		
Carefirst ID Number			
Does Client Live Alone	YES ☐ NO ☐ If No, provide full names of all people living at property and their relationship to Client:		
	Name	**Relationship to Client**	

Contact regarding the Visual Impairment Team Assessment		
Who should be contacted regarding the Assessment	☐ Client ☐ Other If 'other' is chosen, please specify who should be contacted below:	
Preferred method of contact		
Name	**Relationship to Client**	**Contact Telephone Number**

Reason for Referral **Please provide as much detail as possible:**	
Has Patient been referred to another Service e.g. Physio, Rehab OT etc	YES ☐ NO ☐ If yes, please specify

Client's Medical Condition	
Please specify the Client's medical condition(s) previous and present relevant conditions	
Eye Condition	
Registration Status	
Is Client's condition terminal or do they require palliative care?	YES ☐ NO ☐ If yes, has a DS1500 form been completed? YES ☐ NO ☐

GP Details	
GP's Name	
Practice Name	
Address	
GP's Telephone Number	

Accommodation Details	
Accommodation Type	☐ Care home ☐ Mainstream ☐ Nursing Home ☐ Sheltered accommodation ☐ Unknown
Tenure Type	☐ Council ☐ Owner Occupier ☐ Social Housing detail Housing Association if known: ☐ Private accommodation arrangements Other (detail):
Does property have any adaptations?	YES ☐ NO ☐ If yes, provide details:

Hospital Discharge Details	
Is Client currently residing in Hospital or has recently been discharged?	YES ☐ NO ☐ If No, go to next section – 'Referral Details' If Yes, carry on with this section of the form.
Date Client was / is due to be discharged	
Where will the Client be discharged to i.e. home, another hospital etc	
Please list any equipment / adaptations essential for discharge	

Referrer Details	
Name	
Designation	
Organisation	
Address	
Contact Telephone Number	
Date	

Please complete and email this form to:
visualimpairment@aberdeenshire.gov.uk