

Referral Form for Low Vision Aid Assessment

Dear Patient,

Please take a copy of this form duly completed when attending your Low Vision Aid Appointment with a local Provider. Without this the Low Vision Assessment cannot take place.

Details of Providers will have been given to you by your Optician.

Dear Provider of Low Vision Aid Services,

I am referring the person detailed below to you because poor eyesight is making their daily life difficult. I would like your to discuss the range of low vision aids available.

Patient Name: _____

Date of Birth: _____

Patient Address: _____

Postcode: _____

Telephone Number: _____

Other Contact Details: _____
(if applicable)

Referrer Details (Practice Stamp)

Optometrists Report

I feel that _____ (Patients Name) independence has been greatly reduced because of their sight loss. I have examined the above on _____ (Date)

Findings:

	Vision	Sph	Cyl	Axis	△	VA	VA with PH	Add	NVA
R									
L									

Existing Eye Conditions (if known)

Cataract

Macula Degeneration wet/dry

Patient been seen/not been seen by HES (please delete as appropriate)

Diabetic Retinopathy

Please give further details

Glaucoma

Other

Patient Age (Please Tick)

Under 18 Years

18—59 Years

60—74 Years

Over 75 Years

Yours Sincerely

Signature of Referrer:

Date:
