NHS
Fareham & Gosport and
South Eastern Hampshire
Clinical Commissioning Groups

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)

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Referrer Details (Practice Stamp)

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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:

_______________________________ _______________________