NHS
Portsmouth
Clinical Commissioning Group

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 an Optometrist that provides this service. Without this form the Low Vision Assessment cannot take place. A list of participating Optometrists has been provided for you.

Dear colleague,

I am referring the person detailed below to you as reduced eyesight is impacting on their daily living. This person requires a Low Vision assessment under the terms of the NHS Portsmouth CCG Locally Commissioned Service .

Patient Name: _____

Date of Birth: _____

Patient Address: _____

_____

Postcode: _____

Telephone Number: _____

Other Contact Details: _____
(if applicable)

Patient Age (Please Tick)

Under 18 ☐ **18-59** ☐ **60-74** ☐ **75+** ☐

Referrer Details (Practice Stamp)

Optometrists Report

I have examined the patient on _____ *(Date)*

Findings:

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

Supporting information _____

_____

_____

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 below)

_____

_____

☐ Glaucoma

☐ Other (please state below)

_____

Supporting information _____

_____

Are the patient's spectacles made up to the most recent prescription? Y/N ☐

Yours Sincerely
Signature of Referrer: Date:

_____ _____