BlindAid

**Sight Support Service Referral Form**

This form may be completed by an employee of a statutory organisation or registered charity. It may also be completed on behalf of anyone who is blind or partially sighted by family or friends. All applications are evaluated using the information provided here, so please be as clear and accurate as possible.

Please complete this form online or print, complete and return to the address below.

|  |  |
| --- | --- |
| **Service User Details (required)** | |
| Title: | |
| First name: | |
| Surname: | |
| Address: | |
| Borough: | Postcode: |
| Date of birth (dd/mm/yy) | E-mail Address (if known): |
| Home Tel No: | Mob No: |
| Does the individual consent to this referral? | * Yes * No |
| Does the individual consent to BlindAid holding and processing this data for the purpose of providing service? | * Yes * No |
| Does the individual consent BlindAid contacting them via the following: | * Phone * Post |
| Is the individual a permanent UK resident? | * Yes * No |

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| --- | --- | --- | --- |
| Does the individual live alone? | | * Yes * No | |
| If English is not spoken - what is first language? | |  | |
| **Health & Well Being (required)** | | | |
| Registered SSI/blind or SI/partially sighted? | | * Registered SSI/blind * Registered SI/partially sighted * Not registered | |
| Date registered blind or partially sighted (dd/mm/yy) | |  | |
| Eye Condition: | |  | |
| Disabilities: | | * Physical * Hearing * Learning Disability * Other | |
| Details of other disabilities or long term conditions: | | | |
| Details of any mental health issues: | | | |
| We offer home visits to some service users. Do you have any safety concerns about us sending a member of staff to this service user’s home? | | | |
| **How will the individual benefit from our Sight Support service? (Required)** | | | |
| Please provide as much detail as possible: | | | |
| **GP Contact Details (if available):** | | | |
| GP Name: | | | |
| GP Address: | | | |
| **Details of person submitting this application (required)** | | |
| First Name: | | |
| Surname: | | |
| Name of Organisation: | | |
| Address of Organisation | | |
| Telephone number: | | |
| Email address: | | |
| Declaration by person submitting the application:  To the best of my knowledge the information I have provided is complete and accurate and I personally support this application | * Yes * No | |
| **FOR OFFICE USE ONLY** | | |
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