**ECLO Client Referral Form -** CONFIDENTIAL 

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| **Title:**  | Practice name / stamp: |
| **Name:**  |
| **Phone Number:**  |
| **Email address:** | **DOB:**  |

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| **If making a referral on behalf of someone please complete the boxes below:**  |
| **Name:**  | **Nature of relationship:**  |
| **Contact details:**  |

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| **Eye condition/s if known**  |
| Please give as much info as possible on history so far including HES appointments, certification, specific needs and last eye examination details, vision details and any urgent needs. |

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| **Does the person have any additional needs that we need to know about?** E.g.: |
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| **Registration status**  |  |
| Registered Sight Impaired (Partially Sighted) |  |
| Registered Severely SightImpaired (Blind) |  |
| Not Registered |  |
| Does not know if registered |  |
| Has the person been in contact with Gloucestershire County Council, Sensory Impairment Team? (01452 426868) : |  |

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| **Preferred method of communication** |  |
| Telephone |  |
| Email |  |
| Large print letter in post |  |
| Standard print letter in post |  |
| Braille |  |
| Audio  |  |
| Face to face |  |

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| **Services Required – Please tick all boxes that apply**  |  |
| **Information and Advice Service** – To help identify the support required, understand eye condition, find local services, etc.  |  |
| **Low Vision Clinic** – Specialist sight test to assess remaining vision, loan of a prescribed magnifier and advice about aids and equipment |  |
| **Aids, Equipment and Adaptations**– Supplier and service provider information. Demo of basic equipment.  |  |
| **Short Term Support Work** – Support to remain living independently. |  |
| **Group activity:** Attendance at a regular support group providing information, entertainment and friendship. |  |
| **Cookery:** Basic or Advanced skills (Please state) |  |
| **Volunteers** –Assistance from a volunteer to enjoy social or leisure activities or help with basic daily living tasks.  |  |
| **Newsletter – Please circle preferred format:** Large Print Memory stickBraille  |  |
| **Other - Please give details:**  |  |
| **Relevant Additional Information** (please continue on an additional sheet if necessary)**:**Any personal circumstances that we need to be aware of.. |
| **Completed By:** **Date:**  |

**Please return this form to:**

Gloucester HES : **Louise Birt**: Tel: 07702961060 Email: Louise.birt@rnib.org.uk

Cheltenham HES: **Gary Learmonth**: Tel: 07925034799 Email: gary.learmonth@rnib.org.uk

**Office use only**

Date sent: Date Loggd: By Whom: