

The Guardian Centre

67 Clarendon Road

 Colliers Wood

SW19 2DX

 020 8540 5446

info@mertonvision.org.uk

Referral to MertonVision

**Date of referral:**

**GDPR - Do we have the client’s consent to pass information to other health professionals if required:**

**Next of Kin:**

Name:

Relationship to client:

Telephone number:

Email:

**Referral Made By (if not self-referral):**

Name:

Tel:

Email:

Company/Organisation:

**GP details:**

Surgery:

GP name (if known):

Address:

Telephone number:

Email:

**Referral for:**

Title:

Forename:

Family Name:

Date of Birth:

Address:

Postcode: ­­­­­­­­­­­­­­­

Contact number/s:

Email:

NHS Number (if known):

Is an interpreter required?

Preferred Language/Format:

Ethnicity:

Lives alone:

Any support in place (via Local Authority, Independent Sector, Family/Friends):

**Vision Information:**

Eye Condition/s or Information:

Registered/CVI status?: SI / SSI / Unregistered

**Reason for Referral:**

Please let us know what you’re looking for support with, what you’re struggling with so we can plan how best to support you:

**Physical Health:**

Please note any physical or health conditions you feel we need to know about or may affect what support we can offer. Please include hearing:

**Support required:**

Please help us refer you to the right person to speed up your process by putting Yes or No after the following:

General Information about MertonVision:

Low Vision Clinic Appointment:

Vision Rehabilitation – Initial Assessment of Needs:

Vision Rehabilitation – Daily living skills:

Vision Rehabilitation – Mobility Training:

Working Age Group social activities (18-64):

Employment Support/Preparation (18-64):

Social activities (65+):

Volunteer/befriender:

Accessible technology:

**Risk assessment:**

We are committed to keeping staff and service users safe. Are there any potential risks that you should make us aware of?

Any risk reducing actions that you would advise us to take?