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**Central Lancs and South Ribble**

**Low Vision Assessment Referral Form**

Please ensure that the patient has seen an optometrist in the last 12 months. Ask the patient to bring their current prescription to the appointment along with any magnifiers and spectacles they are using.

Please tick which clinic you would like to refer to

|  |  |
| --- | --- |
| Preston  Galloway’s, Howick House, Howick Park Avenue, Penwortham, PR1 0LS |  |
| Chorley  Location TBC |  |

|  |  |
| --- | --- |
| **Patient Name** |  |
| **DOB** |  |
| **Address** |  |
| **Telephone 1** |  |
| **Telephone 2 (relative or friend)** |  |
| **Name for Tel 2** |  |
| **Email** |  |
| **Optometrist practice (optician) And**  **Location** |  |
| **Date of last sight test** |  |
| **Is the patient attending a hospital eye clinic?**  If yes, which hospital? |  |
| **GP details** |  |
| **Eye Condition(s)** |  |
| **Reason for referral / main issues** |  |
| **Binocular Reading Acuity if known** |  |
| **Additional useful Information**  **For example hearing impaired /learning disability/dementia/ mobility issues/ stroke / tremor/ ability to grip)** |  |
| **Has patient attended low vision clinic before?** |  |
| **What aids does patient use already?**  **Include brand and strength of magnifier if known** |  |
| **Does the patient have task lighting?** |  |

**Referral Source Information**

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| **Organisation Name** | Galloways |
| **Referrer Name** | Nicola Smith |
| **Telephone** | 01772744148 |
| **Email** | Nicola.smith@galloways.org.uk |
| **Date of Referral** | 05/04/2022 |

Please send this referral form to [galloways.lowvision@nhs.net](mailto:galloways.lowvision@nhs.net)