SIGHT MATTERS REFERRAL FORM

Please complete with as much information as possible. When completed, please email referrals@sightmatters.im

We aim to respond to all referrals within 5 working days

Person Requiring Support:	**Title**	**Full Name**		**Preferred Name**
	Marital Status	**Date of Birth**	**Age:**	**Gender**
	Home Address		**Current Address if different**	
	Contact Details Including Email Address:		**Preferred Contact Times And Method of Contact**	

Next Of Kin/ Significant Others:	**Name and Relationship:**	**Address:**	**Contact Details**

CONSENT: People giving consent should have the capacity to understand what they are consenting to, be able to give consent voluntarily without pressure and have the capacity to make decisions about their care & support needs.
If Sight Matters has been contacted on behalf of another person, consent must be obtained before any personal information can be requested or disclosed (The exception to this would be if the person lack the capacity to consent due to impaired cognition)

Has the person given consent to share information? (with professionals and/or family members)	**Yes or No**	**Date Consent was obtained:**	**Details of any exceptions to sharing information:**
If the person does not have capacity to consent. Please state the reasons			

Please describe Social Circumstances: Including the living situation, accommodation, occupation, school or college attended, relationships with family and friends, dependents, carers required

Please describe Communication Ability: including first language, preferred communications methods, communication abilities, sensory impairment(s), communication aids used/required

Please give details of Eye Condition (Add any information of relevance which may have an impact on this referral and indicate when the diagnosis was made

Details of any other medical or health conditions relevant to this referral

Please list Risks /Concerns (to the person and practitioners): include known risks caused by physical or mental health problems, environmental risks, lone worker, suicide risk, behaviours, risks to and from others, animals~~)~~

Please list Support Services Or Other Third Sector Agencies Already Involved

Please Provide Any Other Information That May Be Relevant to This Referral If It Has Not Already Been Captured Elsewhere

Practitioner/ Clinician making the referral	**Name**	**Designation**	**Date and Time**	**Contact Info**

If someone other than the person or a practitioner contacted Sight Matters: Who was this and what is their relationship to the person:

To be completed by <u>the Social, Welfare and Inclusion Lead</u>:		
Date Received:	**Received By:**	**Actions Taken:**

Sight Matters Contact Details:

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