



BURY SOCIETY FOR BLIND AND PARTIALLY SIGHTED PEOPLE

Wolstenholme House, 4 Tenterden Street, Bury BL9 0EG

Tel: 0161 763 7014

Email: admin@buryblindsociety.org adultcareservices@bury.gov.uk

Referral Form

Please complete all parts of this form as missing information may lead to a delay in service

admin@buryblindsociety.org

adultcareservices@bury.gov.uk

Title:	Address:
Full Name:	
Date of Birth:	
Gender:	Area:
	Telephone:
NHS Number:	Alternative telephone:
Ethnic Origin:	Marital Status:
Where did you hear about us?	Eye Condition:
Not Registered <input type="checkbox"/>	Speech Impairment Yes <input type="checkbox"/> No <input type="checkbox"/>
Registered Partially Sighted (SI) <input type="checkbox"/>	
Registered Blind (SSI) <input type="checkbox"/>	Hearing Impairment Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Hospital or clinic	Consultant name
Does client require an interpreter to be present? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes what is required language?	
Mobility aid used?	
Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking stick <input type="checkbox"/> Long cane <input type="checkbox"/>	
Any history of falls:	
General Health/ Disabilities	



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Service required

Mobility Assessment Home assessment Eye Talk Programme

Lighting assessment

Other: please state

At Clients home or Office Support Clinic

Why is service required?

Client lives alone Yes No

Receive any support from Family or friends Yes No

Preferred method of communication:

Large Print Email Telephone

Referral completed by:

Referral organisation:

This information will be stored on our database and will be passed to Adult Care Services and other third party agencies that may be able to help provide services for you.

Please sign and date your acceptance of these conditions.

Client aware of referral Yes No Consent given: Yes No

Date of referral: