Family/Self Referral Form

Before submitting this form, a referrer MUST ensure the referred person is aware of, and has consented to, being referred to VisAbility Tasmania. A referral cannot be accepted without consent.

Is the referred person aware of, and has consented to, this referral? ☐**YES** ☐**NO**

Please complete as much of this form as you can and return to VisAbility Tasmania:

Email: referralstas@visability.com.au **Fax:** (03) 6232 1221	**Mail South:** VisAbility Tasmania PO Box 82 North Hobart, 7002	**Mail North:** VisAbility Tasmania 62 Invermay Road Invermay, 7248

Date: _____

Title: ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ MASTER ☐ Other: _____

First Name: _____ **Middle Names:** _____

Surname: _____ **Date of Birth:** _____

Residential Address: _____

_____

Daytime Phone Number: _____ **Mobile Phone Number:** _____

Email Address: _____

Funding Sources (if applicable):

- ☐ **Department of Veterans Affairs (DVA)**
- ☐ **National Disability Insurance Scheme (NDIS)**
- ☐ **Insurance Claim**
- ☐ **Aged Care Package**
- ☐ **Better Start Package**
- ☐ **Other (please provide details below)**

Please provide funding details (relevant registration numbers, contact details): _____

_____

_____

_____

Ophthalmologist: _____ Practice Name: _____

Address: _____

Optometrist: _____ Practice Name: _____

Address: _____

General Practitioner: _____ Practice Name: _____

Address: _____

Which eye condition(s) do you have:

☐ Macular Degeneration ☐ Retinitis Pigmentosa ☐ Cataracts

☐ Diabetic Retinopathy ☐ Neurological Vision Loss ☐ Glaucoma

☐ Related to a Stroke ☐ Related to a Head Injury ☐ Other – Please specify

Any other relevant health information: _____

_____

_____

Do you have any of the following medical conditions:

☐ Asthma ☐ Arthritis ☐ Diabetes ☐ Epilepsy

☐ Heart Condition ☐ Hearing Impairment ☐ Hearing Aids Worn ☐ Other – Please specify

Any other relevant health information: _____

_____

_____

Does your eye condition affect any of the following tasks:

☐ Reading/Writing ☐ Walking safely and confidently

☐ Household Tasks ☐ Transport/Out and about in the community

☐ A bit of everything ☐ Coping with the stress of Vision Loss

☐ Other – Please specify: _____

_____

_____

VisAbility Tasmania will make contact with the client before finalising this referral to gain further details and discuss VisAbility Tasmania services.

Do you have any further information which may assist us to support you: _____

_____

_____

_____

_____

_____

Where did you find out about VisAbility & Guide Dogs Tasmania Services: _____

_____

_____

Referrers Details:

Name: _____ Relationship to client: _____

Address: _____

Phone: _____ Email: _____

If you are referring someone under 18 years of age, please complete page 4

Child/Under 18 Information

Parent/Guardian Name(s): _____

Address: _____

Phone Number - Home: _____ **Work:** _____

Mobile Phone Number(s): _____

Email Address: _____

Child's Current Grade: _____

School Name: _____ Phone: _____

Address: _____

Learning Support Co-ordinator: _____

Phone: _____ Email: _____

Class Teacher: _____

Phone: _____ Email: _____

Teacher Aid/Assistant: _____

Phone: _____ Email: _____

Principal: _____

Phone: _____ Email: _____

Resource Teacher/Education Officer - Vision: _____

Phone: _____ Email: _____

Contact details of other relevant people involved at school: _____

_____

_____

Does the child receive services from other organisations (eg St Giles, RIDBC)? Details:

_____

_____

_____

Do you have any further information which may assist us to support this child: _____

_____

_____