VisionPK Referral Form

VisionPK **Perth and Kinross Sensory Centre** **14 New Row, Perth, PH1 5QA**	**Telephone: 01738 626969** **email: info@visionpk.org.uk** **www.visionpk.org.uk**

Referral FROM	
Has the person agreed to referral to VPK?	
How did you come to know about us?	
Referrer's Name:	
Hospital/Organisation (if applicable):	BP1 (CVI) ☐
Address:	
Postcode:	
Telephone:	
email:	

Details for person being referred	
Title:	Date of Birth:
Name:	
Address:	
Postcode:	
Telephone:	
email:	

Sensory loss details
Sight impaired: SSI (Blind) ☐ SI (Partially Sighted) ☐ Not Certified ☐ Not sure ☐
Hearing impaired: Deaf ☐ Hard of Hearing ☐ Don't know ☐
Does the person wear a hearing aid?

Reason for Referral (and any risks identified e.g. lives alone; additional support needs; other services involved)

Referral received/taken by:	Date:
Date passed to CST:	FW allocated to: