# Referral Form

Please complete as much of this form as possible

| **Learner Information** |  |
| --- | --- |
| **Date of Referral:** | ORS: |
| **Learner’s Name:** | DOB: |
| Ethnicity: | Gender: |
| Home language: | NHI Number: |

| **Parent/Caregiver Information** |  |
| --- | --- |
| Name: | Name: |
| Address: (please include postcode) | Address: (please include postcode) |
| Email address: | Email address: |
| Contact phone numbers: | Contact phone numbers: |

| **Consent given for** |
| --- |
| Functional Vision Assessment  Visual Resource Centre to access clinical eye/medication information  VRC to share information  **Parent/Caregiver Signature:** |

| **Referring Agent** |  |
| --- | --- |
| Name:  Position and Contact:  Other Agencies Involved: | Date: |

| **Reason for referral** |
| --- |
| **Eye condition, acuity, vision concerns etc.?**  **Other medical/education difficulties:**  **Name of eye and/or other specialist:** |

| **Educational Setting** |  |
| --- | --- |
| School/Centre: | Class Level: |
| Address: | Contact/support staff: |
| Phone: | Email: |

Please send the completed form, along with any clinical reports, to BLENNZ Auckland South Visual Resource Centre.