CONFIDENTIAL

(Please return this form via email to info@iC2.com.sg)

Referral Form

DATA PROTECTION: The information collected in this form shall be used to assess the suitability of the child to receive services from iC2 PrepHouse Limited. If the child is determined to be unsuitable, the information shall be deleted and no information shall be retained. If the child is deemed suitable, the personally identifiable information shall be kept as part of the records for the child until such time as the child is withdrawn or discharged, to the legal limits for data retention. The information may be anonymised for various research purposes.

CHILD'S INFORMATION

Name per BC/NRIC/FIN/Passport		**BC/NRIC/FIN/Passport No.**
Date of Birth (dd/mm/yyyy) / /	**Gender** ☐ Male ☐Female	**Nationality**
Address		**Postal Code**
Name of Contact Person		**Relationship to Child**
Contact Info (mobile and/or email)		

REFERRING PERSON

Name	
Email	
Organisation and Address	**Phone No.**
Relationship to child: ☐ Doctor ☐ Low Vision Clinician ☐ Teacher* * Teachers: Please attach the child's low vision and/or medical report.	

EYE SPECIALIST

Name of Eye Specialist (☐ Please tick this box and skip this section if the referrer is also the eye specialist)	
Email	
Name and Address of Practice	**Phone No.**

DETAILS OF EYE CONDITION (to be completed by eye specialist)

Date Tested / / **Diagnosis** **Age at Onset**

	Right Eye	**Left Eye**
Refraction		
Visual Acuity **Distance**		
Visual Acuity **Near**		
Visual Field Specifics (if abnormal):	☐Untested ☐Normal ☐Abnormal	☐Untested ☐Normal ☐Abnormal
Colour Vision Specifics (if abnormal):	☐Untested ☐Normal ☐Abnormal	☐Untested ☐Normal ☐Abnormal
Prognosis ☐ Likely to improve ☐ Remain stable ☐ Deteriorate ☐ Other Specifics:		

OTHER INFO

Low Vision Report (if available)
Other medical concerns (including medications)
Other Agencies / Specialists working with the child:

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