

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 PreHouse 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personally identifiable information shall be kept as part of the records for the child until such time as the child is withdrawn or discharged, to the legal limits for data retention.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. You may view <http://ic2.com.sg/referral/> for more information.

CHILD'S INFORMATION	Name per BC/NRIC/FIN/Passport		BC/NRIC/FIN/Passport No.
	Date of Birth (dd/mm/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Doctor <input type="checkbox"/> Low Vision Clinician <input type="checkbox"/> Teacher* * Teachers: Please attach the child's low vision and/or medical report.		

EYE SPECIALIST	Name of Eye Specialist (<input type="checkbox"/> 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 Near		
	Visual Field	<input type="checkbox"/> Untested <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Untested <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	Specifics (if abnormal):		
	Colour Vision	<input type="checkbox"/> Untested <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Untested <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Specifics (if abnormal):			
Prognosis	<input type="checkbox"/> Likely to improve <input type="checkbox"/> Remain stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> 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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