Referral Form

CHILD'S INFORMATION

Name of Child | **Date of Birth** | **Gender** ☐ Male ☐ Female

BC / NRIC No. (Singapore Citizens and Permanent Residents) | **Passport No.** (non-Singaporeans)

Address

Name of School / Institution

Name of Caregiver | **Phone No.**

REFERRING PERSON

Name | **Phone No.**

Organisation and Address

Email

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)

Phone No.

Name and Address of Practice

Email

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

Date | **Diagnosis** | **Age at Onset**

	Right Eye	**Left Eye**
Refraction		
Visual Acuity **Distance**		
Near		
Visual Field Specifics (if abnormal):	☐ Untested ☐ Normal ☐ Abnormal	☐ Untested ☐ Normal ☐ Abnormal

Colour Vision ☐ Untested ☐ Normal ☐ Abnormal
Specifics (if 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**

** please use the other side of this page if more space is needed