

Family/Self Referral Form

Before submitting this form, a referrer MUST ensure the referred person is aware of, and has consented to, being referred to VisAbility Tasmania. A referral cannot be accepted without consent.

Is the referred person aware of, and has consented to, this referral? YES NO

Please complete as much of this form as you can and return to VisAbility Tasmania:

Email:
referrals@guidedogstas.com.au

Mail South:
VisAbility Tasmania
PO Box 82
North Hobart, 7002

Mail North:
VisAbility Tasmania
62 Invermay Road
Invermay, 7248

Fax: (03) 6232 1221

Date: _____

Title: MR MRS MS MISS MASTER Other: _____

First Name: _____ **Middle Names:** _____

Surname: _____ **Date of Birth:** _____

Residential Address: _____

Daytime Phone Number: _____ **Mobile Phone Number:** _____

Email Address: _____

Funding Sources (if applicable):

- Department of Veterans Affairs (DVA)
- National Disability Insurance Scheme (NDIS)
- Insurance Claim
- Aged Care Package
- Better Start Package
- Other (please provide details below)

Please provide funding details (relevant registration numbers, contact details): _____

Ophthalmologist: _____ **Practice Name:** _____

Address: _____

Optometrist: _____ **Practice Name:** _____

Address: _____

General Practitioner: _____ **Practice Name:** _____

Address: _____

Which eye condition(s) do you have:

- | | | |
|---|---|---|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinitis Pigmentosa | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Neurological Vision Loss | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Related to a Stroke | <input type="checkbox"/> Related to a Head Injury | <input type="checkbox"/> Other – Please specify |

Any other relevant health information: _____

Do you have any of the following medical conditions:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Hearing Aids Worn | <input type="checkbox"/> Other – Please specify |

Any other relevant health information: _____

Does your eye condition affect any of the following tasks:

- | | |
|--|---|
| <input type="checkbox"/> Reading/Writing | <input type="checkbox"/> Walking safely and confidently |
| <input type="checkbox"/> Household Tasks | <input type="checkbox"/> Transport/Out and about in the community |
| <input type="checkbox"/> A bit of everything | <input type="checkbox"/> Coping with the stress of Vision Loss |
| <input type="checkbox"/> Other – Please specify: | _____ |

VisAbility Tasmania will make contact with the client before finalising this referral to gain further details and discuss VisAbility Tasmania services.

Do you have any further information which may assist us to support you: _____

Where did you find out about VisAbility & Guide Dogs Tasmania Services: _____

Referrers Details:

Name: _____ Relationship to client: _____

Address: _____

Phone: _____ Email: _____

*****If you are referring someone under 18 years of age, please complete page 4*****

Child/Under 18 Information

Parent/Guardian Name(s): _____

Address: _____

Phone Number - Home: _____ **Work:** _____

Mobile Phone Number(s): _____

Email Address: _____

Child's Current Grade: _____

School Name: _____ **Phone:** _____

Address: _____

Learning Support Co-ordinator: _____

Phone: _____ **Email:** _____

Class Teacher: _____

Phone: _____ **Email:** _____

Teacher Aid/Assistant: _____

Phone: _____ **Email:** _____

Principal: _____

Phone: _____ **Email:** _____

Resource Teacher/Education Officer - Vision: _____

Phone: _____ **Email:** _____

Contact details of other relevant people involved at school: _____

Does the child receive services from other organisations (eg St Giles, RIDBC)? Details:

Do you have any further information which may assist us to support this child: _____

