**SINGAPORE ASSOCIATION OF THE VISUALLY HANDICAPPED (SAVH)**

**CLIENT REFERRAL FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client’s Particulars** | | | | | |
| Name |  | | | | |
| NRIC No. |  | | Date of Birth | |  |
| Contact No. | (H) | | (HP) | | |
|  | *(Please indicate contact person’s name / relationship with client, if applicable)* | | | | |
| Address |  | | | | |
|  | | | | | |
| **Doctor’s Referral** | | | | | |
| **Blindness** | | | **Low Vision** | | |
| < 3/60 or corresponding visual field loss in the better eye with best possible correction | | | < 6/18, but equal or better than 3/60 in the better eye with best possible correction | | |
| Diagnosis |  | | | | |
| Visual Acuity | (R) | | | (L) | |
| Visual Field | (R) | | | (L) | |
| Service(s)  Referred For  ( Please Select) | Low Vision Clinic  Vision Rehabilitation Programme (e.g. Orientation & Mobility, ADL Training)  Social Work Service / Counselling  Skills Training / Job Placement  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | | | | |
| **Name & Signature of Doctor** | | **Official Stamp** | | | **Date of Referral** |
|  | |  | | |  |

Please email completed form to [lvc@savh.org.sg](mailto:lvc@savh.org.sg) or send to:

47 Toa Payoh Rise Singapore 298104

Tel: (65) 6251 4331

Website: [www.savh.org.sg](http://www.savh.org.sg)