**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 ([x]  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 or send to:

47 Toa Payoh Rise Singapore 298104

 Tel: (65) 6251 4331

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