

CLIENT REFERRAL FORM

Client's Particulars			
Name			
NRIC No.		Date of Birth	
Contact No.	(H)	(HP)	
<i>(Please indicate contact person's name / relationship with client, if applicable)</i>			
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 (<input checked="" type="checkbox"/> Please Select)	<input type="checkbox"/> Low Vision Clinic <input type="checkbox"/> Vision Rehabilitation Programme (e.g. Orientation & Mobility, ADL Training) <input type="checkbox"/> Social Work Service / Counselling <input type="checkbox"/> Skills Training / Job Placement <input type="checkbox"/> 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