Referral for low vision services

SensesWA
Your trusted partner in disability

1300 111 881 customerservice@senses.org.au senseswa.com.au

Individual's details

Surname: _____ First name: _____

Address: _____

Postcode: _____ Date of Birth: _____

Gender: _____

Funding: ☐ NDIS ☐ Private ☐ Other _____

Communication details

Email: _____ Phone: _____

Preference: ☐ Email ☐ Phone ☐ Other _____

Interpreter ☐ Yes ☐ No

	Right Eye	Left Eye	Both Eyes
Diagnosis:			
Visual acuity:			
Visual Field in degrees			

Any other relevant information: _____

Attached supporting documents / reports ☐ Please provide copy of recent field test.

Referred by Ophthalmologist / Optometrist / Other: _____

Signature: _____ Date: _____

Name (print): _____

Address: _____

Please retain a copy for your own records and send a copy to:
Email: customerservice@senses.org.au
Address: PO Box 811 Victoria Park WA 6979 Fax: (08) 9473 5499