BISS
Buckinghamshire Integrated Sensory Service

BucksVision
Visual Impairment Charity

Buckinghamshire Council

BISS INITIAL CONTACT/ REFERRAL FORM*

GENERAL DETAILS	
Date of referral	
Client's name	
Address	
Date of Birth	
LAS no	
Gender	
Ethnicity	
Clients phone number	
Clients email address	
GP details	
Does client need to be contacted in a specific way?	
Does client need information in a specific format?	

SENSORY LOSS DETAILS	
SIGHT LOSS	
Sight loss condition/s if known	
Registration details if known	
HEARING LOSS	
Registration details if known	
Any hearing aids worn? Number?	
Any tinnitus? Please give details	
Does the individual have dual sensory loss?	

HEALTH ISSUES	
Any general health issues?	
Do you have a pacemaker?	
Does client have any memory loss or dementia?	

COMMUNICATION METHOD OR PREFERENCE	
Does client have a specific communication need? Please give details	
Does client need professional communication support? Please give details	

PREMISES	
Any issues with access to premises	
Does client live alone?	
Private or rented?	

REASON FOR REFERRAL	

CONSENT	
Client consent given for referral and data collection	Y/N
If not direct client consent, please check and note that client is aware and happy with the referral	

Referred by:	
Referrers contact no:	
Referrer's role/relationship to client:	
Date:	
Other information/taken by:	

Return to: Bucks Sensory Service, 143 Meadowcroft, Aylesbury, HP19 9HH
Tel: 01296 479970 Email: biss@bucksvision.co.uk

FOR OFFICE USE ONLY	FOR OFFICE USE ONLY
Referral received by:	
Date referral received:	