**BISS INITIAL CONTACT/ REFERRAL FORM\***

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| **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?** |  |

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| **SENSORY LOSS DETAILS** | |
| **SIGHT LOSS** | |
| **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?** |  |

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

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

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| **PREMISES** |  |
| **Any issues with access to premises** |  |
| **Does client live alone?** |  |

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| **REASON FOR REFERRAL** |  |

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| **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** |  |

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| **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**

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