

Referral Form



Association
for the Blind of WA
Guide Dogs WA

Surname:

First Name:

Address:

Post Code:

Male Female

Date Of Birth: / /

Phone:

Date Last Examined:

DVA Gold Card

	Right Eye	Left Eye	Both
Best corrected distance visual acuity	/	/	/
Visual field in degrees diameter	o	o	
OR Describe field loss (Please provide a copy of the most recent field test)			

Probable cause of visual problems:

Any other relevant details:

Referred by GP/Health Professional (please state profession):

Signature:

Date: / /

Name (Print):

Address:

Please retain a copy for your own records and forward a copy to:

The Association for the Blind of WA - Guide Dogs WA

61 Kitchener Avenue, Victoria Park WA 6100

Phone: (08) 9311 8202

Fax: (08) 9361 8696

Email: info@guidedogswa.com.au

Consent for Registration



I would like to be registered with the Association for the Blind of Western Australia. I have been given and understand the information sheet about the Association for the Blind of Western Australia, and their services.

I understand the Association for the Blind of Western Australia will contact me about their services. I agree that the details on 'Low Vision Medical Certificate' will be provided to the Association for the Blind of Western Australia on the understanding that all information provided is treated as confidential.

I agree that my information may be used by the Association for the Blind of Western Australia for research aimed at supporting and benefiting people who are blind or have vision impairment in Western Australia. I understand that I can withdraw my consent for my personal information to be used for research by contacting the Association for the Blind of Western Australia.

Signature: _____ **Date:** / /
(Parent/Guardian if person is under 16 years of age)

Name: _____
(Parent/Guardian if person is under 16 years of age)

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