



**Association  
for the Blind of WA**  
Guide Dogs WA

# Referral for Low Vision Assessment

SURNAME: .....

FIRST NAME: .....

ADDRESS: .....

..... Post Code:.....

Date of Birth: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ Phone: .....

Male  Female

**Date last examined:** \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ DVA Gold Card

Right eye                      Left Eye                      Both

**Best corrected distance  
visual acuity**

\_\_\_ \_\_\_ / \_\_\_ \_\_\_

\_\_\_ \_\_\_ / \_\_\_ \_\_\_

\_\_\_ \_\_\_ / \_\_\_ \_\_\_

**Visual field in degrees  
diameter** 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 Optometrist / GP / Other:**

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**

**Fax:** (08) 93618696 **Phone:** (08) 9311 8202

**Address:** 61 Kitchener Avenue, Victoria Park WA 6100

**Email:** info@guidedogswa.com.au

# Consent for registration with the Association for the Blind of Western Australia

**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.

**Signed**.....

**Date** \_\_\_ / \_\_\_ / \_\_\_

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

**Name**.....

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

**Please forward a copy to:**

Association for the Blind of WA,  
61 Kitchener Avenue, Victoria Park WA 6100.  
PO Box 101, Victoria Park, WA 6979  
**Phone: (08) 9311 8202. Fax: (08) 93618696**  
[www.guidedogswa.com.au](http://www.guidedogswa.com.au)