**Transitions Service, Referral Form**

|  |
| --- |
| Referral Source |
| **Your Organisation Details** |  |
| **Your Name** |  |
| **Your Email Address** |  |
| **Your Contact Number** |  |
| **Relationship to Customer** |  |
| **Who else the family has been referred to** |  |

|  |
| --- |
| Young Person |

|  |  |
| --- | --- |
| **Childs Full Name** |  |
| **Childs Date of Birth** |  |
| **Childs Gender** |  |
| **Childs/YP Preferred Format**For Example Braille, Large Print etc |  |
| **Child/YP Preferred Language**For example BSL, Welsh etc |  |
| **Young Persons mobile** **Number** (if applicable) |  |
| **Young Persons Email Address**(if applicable) |  |

|  |
| --- |
| Medical Conditions |
| **Eye Condition** |  |
| **Additional Needs**Include any additional disabilities/difficulties |  |
| **Registration Status**Please tick | **Not Registered** |  | **Severely Sight Impaired** |  | **Sight Impaired** |  |
| **How condition affects them** |  |

|  |
| --- |
| Parents Details (if under 18) |
| **Parents title: Mr / Mrs / Miss etc** |  |
| **Parents/Carers name/names** |  |
| **Home Address 1** |  |
| **Home Address 2** |  |
| **Home Address 3 (Town)** |  |
| **Home Address 4 (County)** |  |
| **Home Postcode** |  |
| **Home Phone Number** |  |
| **Parents Mobile Number** |  |
| **Parents Preferred Format**For Example Braille, Large Print etc |  |
| **Parents Preferred Language**For example Welsh, BSL etc |  |
| **Parents Preferred contact** **Method** (email, phone, post) |  |

|  |  |
| --- | --- |
| **Best time / day to call**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there Lone Worker Risks?** | **Yes** |  | **No** |  |
| **Details if Yes:**  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does parent or Young person (Aged 18+) consent for referral to be made?** | **Yes** |  | **No** |  |
| **Who has given consent** (Name and relationship) |  |

|  |  |
| --- | --- |
| **Reason for Referral** |  |
| **Additional Relevant** **Information** |  |
| **Internal referrals only:**Are the family already on OV2 | **Yes** |  | **No** |  |

**Please return the completed referral to:**

**Transitions Manager, RNIB Cymru, Womanby St, Cardiff CF10 1BR**

**Or e-mail to transitionscymru@rnib.org.uk**

**If you wish to speak to someone regarding this referral please contact our head office on 029 2082 8500 and someone from the Transitions Team will get back to you**

For internal use only:

|  |  |
| --- | --- |
| Date received |  |
| Date initial contact made/attempted |  |
| Allocated to |  |