CHARLES BONNET SYNDROME
FOUNDATION

ABN 35 160 445 090

REFERRAL FORM

DATE _____

CLIENT'S NAME

SURNAME _____ **GIVEN NAME** _____

ADDRESS_____**POST CODE** _____

DATE OF BIRTH _____ **CONTACT NUMBER** _____

REFERRAL SOURCE (Please tick if applicable)

- ☐ SELF
- ☐ FAMILY / FRIEND
- ☐ CASE MANAGER
- ☐ GP
- ☐ OPTOMETRIST
- ☐ ORTHOPTIST
- ☐ OPHTHALMOLOGIST
- ☐ OTHER (*Please list)* _____

NAME _____

AGENCY_____

ADDRESS_____

CONTACT NUMBER_____

E-MAIL_____

VISION

Type of vision impairment? *(eg. macular degeneration, cataracts)*

_____

(Please supply doctor's eye report if accessible)

What type of CBS images are experienced?

_____

_____

Are the CBS images a source of bother or distress for the client?

_____

ASSISTANCE SOUGHT

What form of CBS Foundation assistance do you believe this person would benefit from?
(Please tick if applicable)

- ☐ INFORMATION & SUPPORT
- ☐ SUPPORT GROUP(S)
- ☐ COUNSELLING
- ☐ CASE MANAGEMENT
- ☐ LINKAGE TO COMMUNITY SUPPORTS
- ☐ OTHER (Please outline)

_____

Has the person being referred given consent for this referral to proceed? (if not self-referral)

- ☐ YES
- ☐ NO

Please return the completed referral form to:

CHARLES BONNET SYNDROME FOUNDATION
P.O. BOX 352
FLINDERS LANE, VIC 8009

Other referral options:

E-MAIL referral@charlesbonnetsyndrome.org
FAX 9654 5007
PHONE 1300 121 123
ON-LINE www.charlesbonnetsyndrome.org