

OBAC

ORGANISATION OF BLIND AFRICAN CARIBBEANS

OBAC REFERRAL FORM

*Please supply as much information as you Can.
All information given by third parties may be available
to the client unless reasons for withholding the information
are provided.*

1. THE PERSON BEING REFERRED

SURNAME:**FORENAMES:****TITLE:****DATE OF BIRTH****ADDRESS:****BOROUGH:****POSTCODE:****TEL. NO.:****GENDER** *(Please Tick)* MALE FEMALE **NI NUMBER:****RELIGION****TENURE***Please Tick*

Is the Person Council Tenant

Housing Association Tenant

Private Tenant

Owner Occupier

Other specify _____

Does the Person

Live Alone Yes

No

**COMMUNITY FUND**
Lottery money making a differenceCommunity
Legal Service



2. VISUAL IMPAIRMENT

REGISTRATION

Is the individual registered

BLIND

PARTIALLY SIGHTED

NOT YET REGISTERED

EYE CONDITION

Please give brief details of the individual's visual impairment
(e.g. totally blind, Glaucoma etc.)

How long has the individual had their disability? _____

3. METHOD OF REFERRAL

Referral

Self Referral (Go to Part 4)

or

Referral being made on someone else's behalf

(Please complete boxes below)

Name of Person Making Referral:

Department:

Position:

Organisation:

Address:

Tel. No.

Relationship to Person Referred:

Has the person being referred agreed to this referral being made:-

Yes

No

How did the person making the referral hear about OBAC:

4. COMMUNICATION AND MOBILITY

PREFERRED INITIAL CONTACT

Please Tick One ✓

OBAC contact individual direct

OBAC contact individual's carer

Individual contact OBAC

CARER'S OR NEXT OF KIN DETAILS

NAME:

ADDRESS:

POSTCODE:

TELEPHONE:

PREFERRED MODE OF COMMUNICATION.

Please Tick One ✓

BRAILLE

LARGE PRINT

STANDARD PRINT

MOBILITY

Please Tick One ✓

Does the individual:

Use public transport Yes No Sometimes

Need help mobility Yes No Sometimes

Are they housebound Yes No

Does the individual have: -

Guide Dog

White Cane

Does the individual use:

Taxicard Yes No

Travel permit (disabled or elderly) Yes No

Orange Badge parking permit Yes No

OBAC



5. RETURN OF FORM

Form completed by:

Name:

Address:

Postcode:

Tel. No.

Signature:

Date:

Thank you for completing this form. Please send the form along with the completed OBAC Membership Form to the

**OBAC Offices:
Service Delivery Team
OBAC
Gloucester House
8 Camberwell New Road
London SE5 0RZ**

OBAC

