



**We're here to help with the everyday challenges of sight or hearing loss.**



# SensingChange

Need Help? Contact: Sensing Change

Stone Lodge Community Centre, Ipswich,  
Suffolk IP2 0QY Email:

[sensingchangeinfo@suffolk.gov.uk](mailto:sensingchangeinfo@suffolk.gov.uk)

Tel: 01473 260030 Fax: 01473 263029

Minicom: 01473 604345

## Referral to Sensing Change Team

The information you provide us with will be treated as confidential although we may need to share what you have told us with other professionals. Are you happy for us to share this information? Is there anybody who you do not want us to share information with?

**Please complete the following details about the person that needs to be referred to Sensing Change and return this form to the email or address above. Areas marked with a \* are mandatory, any forms without this information will be returned.**

### REFERRAL MADE BY:

Name*	Address*	Tel No*
Profession/Relationship*	Agency/Team*	Date*
Have you discussed & obtained agreement for this referral? Yes/No		

### \*REFERRAL AND BASIC INFORMATION

FULL NAME*	CF6 ID	DATE OF BIRTH*	GENDER*
PERMANENT ADDRESS*	CURRENT ADDRESS (IF DIFFERENT)*		
POSTCODE*	POSTCODE*		
PHONE NO'S* & EMAIL	MARITAL STATUS*		
ETHNICITY*	LANGUAGE*		

RELIGION*	OCCUPATION*
Nat Ins No*	NHS No:

**Reason for referral**

<b>Please indicate</b>			
Hearing Loss	<input type="checkbox"/>	Support Service Team	<input type="checkbox"/>
Sight Loss	<input type="checkbox"/>		
Dual Sensory	<input type="checkbox"/>		
<b>Reason for referral – Please complete this section with as much information as possible e.g. Diagnosed sensory condition - whether visual or hearing loss* Why is an assessment needed?* What difficulties is the person having?* How urgent is help needed?* Are there allegations of abuse or neglect?*</b>			
<b>HAS THE PERSON BEEN REFERRED TO OTHER TEAMS OR AGENCIES?</b>			
<b>CURRENT SUPPORT –</b>			
<b>COMMUNICATION NEEDS – Large Print, British Sign Language, Audio, Braille*</b>			
<b>GP DETAILS*</b>			
GP Name*	Name of Practice*	Tel No*	
<b>NEXT OF KIN/CONTACT IN AN EMERGENCY</b>			
Full Name*	Relationship*	Date of Birth (If appropriate)*	Gender*
Address*			
Postcode*			
<b>Where did you hear about Sensing Change?</b>			
<b>PLEASE SELECT ONE</b>			

**THANK YOU**

Please now return this form to [sensingchangeinfo@suffolk.gov.uk](mailto:sensingchangeinfo@suffolk.gov.uk)