



**ECLO/Vision Support Service Referral Form**

Affix Patient Sticker Here, Hospital use only

Referred by (Name of organisation)

Consultant/Clinician:

Reason for Referral:

Is the patient happy to be contacted by Vision Support Harrogate Districts Eye Clinic Liaison Officer? If yes, please ensure the patient signs and dates the consent form.

Patient Signature:

Date:

Contact Phone Number:

Clinic/Clerical Staff: Please send completed form to: ECLO, Vision Support Harrogate District, 23 East Parade, Harrogate, HG1 5LF

Office use only

Date Received:

Date Patient Contacted: