**Referral to Local Community Visual Impairment Services Complete and send/email to:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Name** |  | **DOB/CHI** |  |
| **Address and Postcode****Parents Name/Phone****Clinic where Child or Young Person was seen** | **Clinic Type**: **Clinic Location:**  | **Name of school/nursery** |
|  |
| **GP:**  |
| **Type of known / suspected VI** | **Ocular Cerebral Optic Nerve**  |
| **Visual diagnosis (if known)** |  |
| **Other diagnosis (if applicable)** | **Dev Delay ASD Phys Disability Learning Disability****Hearing Impairment Other (please specify):**  |
| **Service Requested**  |  **QTVI assess FVA LVA Hab assess** **Dev/Paeds SW assess Early Intervention Service** |
| **Visual Function** | **Glasses Yes / No Prescription** **Distance VA test used (R) (L) (BEO)** **Near VA test used (BEO)** **Visual Field** **Eye Movements**  |
| **Does the child meet VINCYP criteria?**  | **Yes**  **No** |
| **Agencies/Professionals currently involved eg Paediatrician, VI Teacher** |  |
| **Additional relevant information / parental concerns etc** |
|  |
| **Consent for referral received from parent/carer?** |  **Yes No**  |
| **Date** | **Referrer** | **Job title** | **Address:** **Telephone:**  |