**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:** | | |