VINCYP
Visual Impairment Network for Children & Young People

NHS National Services Scotland

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

Patients Name		**DOB/CHI**	
Address and Postcode **Parents Name/Phone**		**Name of school/nursery**	
Clinic where Child or Young Person was seen	**Clinic Type**: **Clinic Location:**	**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**

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<table>
<tr><td colspan="3">Does the child meet VINCYP criteria?</td><td colspan="2">Yes ☐ No ☐</td></tr>
<tr><td colspan="3">Agencies/Professionals currently involved eg Paediatrician, VI Teacher</td><td colspan="2"></td></tr>
<tr><td colspan="5">Additional relevant information / parental concerns etc</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="4">Consent for referral received from parent/carer?</td><td>Yes ☐ No ☐</td></tr>
<tr><td>Date</td><td>Referrer</td><td>Job title</td><td colspan="2">Address:

Telephone:</td></tr>
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