VINCYP
Visual Impairment Network for Children & Young People

NHS National Services Scotland

Health Feedback Summary

Child's Name …………………………… D.O.B./CHI …………………………..

Visual Diagnosis (as on referral)…………………..……………………………....

Date of initial developmental /disability assessment ……………….........................

Name of Paediatrician..

Other Difficulties Identified (tick all that apply)

- **Developmental Impairment**
- **Learning Disability**
- **Epilepsy**
- **Hearing Impairment**
- **Speech and Language Impairment**
- **Motor Impairment**
- **Behaviour Difficulty**
- **ASD Behaviours - formally diagnosed**
  - **not diagnosed**

Name of person completing ………………………….. Date …………………........…

Base ……………………………...……………………………………….........…….

Telephone...

Please complete and return this form to ....

DRAFT