**Learning Disability Clinic Referral**

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| Patient details | | Referrer details | |
| **Name:** |  | **Department:** |  |
| **DOB:** |  | **Consultant:** |  |
| **HEY:** |  | **Referring clinician:** |  |
| **NHS:** |  | **Designation:** |  |
| **Contact No:** |  | **Date of request:** |  |
| **Any upcoming outpatient appointment Dates:** | | | |

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| **Individuals special needs / diagnosis:** |
| **Details of reason for request:** |
| **Indicate the patients level of functioning, cognition and communication:** |

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| **History** | **Glasses** | **Y/N** |
| Note any known pre-existing conditions: | Does the child usually wear glasses? |  |
| Has the child had glasses in the past? |  |
| Have parent/guardian consented to referral? |  |
| Do parents/ guardians have any concerns? |  |

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| **Have you any concerns with any of the following?** |
| Problems with close work: |
| Problems with distance vision: |
| Do they miss things to one side: |
| Any other comments: |

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| **Please e-mail referral for the attention of Orthoptic Department:**  [**orthoptichey@nhs.net**](mailto:orthoptichey@nhs.net) |