**LVA Service – Orthoptic Department**

**Referral**

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| **Name:** |  | **Date of Referral:** |  |
| **DOB:** |  | **School if applicable** |  |
| **HEY:** |  | **Referring clinician:** |  |
| **NHS:** |  | **Designation:** |  |
| **Team:** | IPaSS / SaPTS | **Contact Number:** |  |
| **Registered:** Yes/No Sight Impaired/Severely Sight Impaired |

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| **Details of condition:** |
| **Current Support/equipment:** |

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| **Ocular problems** (please mark with a ✓) | **Ocular signs** (please mark with a ✓) |
| Double vision |[ ]  Reading difficulties |[ ]  Nystagmus (wobbling eyes) |[ ]  Teacher concerns |[ ]
| Blurred vision  |[ ]  Problems with new environment |[ ]  Closing one eye |[ ]  Family concerns |[ ]

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| **Ocular History** | **Glasses** | **Y/N** |
| Note any known pre-existing conditions: | Does the patient need glasses? |  |
| Should the patient usually wear glasses? |  |
| Does the patient use their glasses? |  |

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| **General Information Y/N** |
| Does the patient or parent/guardian of the patient know about your referral? |  |
| Does the patient or parent/guardian of the patient agree to referral? |  |
| If applicable please ask the parent/guardian to sign below:**Signature: Relationship to child:****Date: Contact number:** |
| Indicate the patients level of functioning, cognition and communication: |

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| **Please e-mail to:****orthoptichey@nhs.net** |