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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | Original Date: | | |  |
|  | | | | | | | Dates Revised: | | |  |
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| Visual Impairment Service **ReferRal Form** | | | | | | | | | | |
| All questions contained in this form are strictly confidential | | | | | | | | | | |
| Name of Child: | |  | | | M  F | DOB: | |  | | |
| Address: |  | | | | | | | | | |
| Email: |  | | | | | | | | | |
| **Parent/Carer**  **names:** |  | | | | | | | | | |
| **Telephone number:** |  | | | | | | | | | |
| **Language Spoken at home** |  | | | | | | | | | |
| **School:** |  | | | | | | | | | |
| **Other agencies involved (e.g. OT, KIDS etc.):** |  | | | | | | | | | |
| Previous or referring doctor: | | |  | Date of last eye appointment (please attach reports): | | | | |  | |
|  | | | | | | | | | | |
| mEDICAL dETAILS | | | | | | | | | | |
|  | | | | | | | | | | |
| Eye Condition | | | | | | | | | | |
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| |  |  |  | | --- | --- | --- | | Parents agree to the referral: |  |  |  |  |  | | --- | --- | | Concernsregarding visual functioning: |  |  |  |  | | --- | --- | | Visual Difficulties:Visual Acuity: |  | |  |  | | | | | | | | | | | |

I give permission for my child’s medical/visual reports/information to be forwarded to the Visual Impairment Team.

**Parents Signature**:…………………………………………………….

*Completed form to be sent to:*

susan.kingo’neill@southwark.gov.uk

Manger Sensory service

SEN Team

Children and Adult Services

Level 4 hub 3

Po box 64529

*If you would like anymore information on anything to do with Visual Impairment, please check out our Local Offer using the link below. This can also be found by searching online for Southwark Visual Impairment Local Offer.*

[*http://localoffer.southwark.gov.uk/education/specialist-services-offered-by-the-council/visual-impairment-team/*](http://localoffer.southwark.gov.uk/education/specialist-services-offered-by-the-council/visual-impairment-team/)