****

**Vision Support Team**

**Referral Form**

**We support children and young people with a vision impairment from 0-25 years old.**

**A vision impairment is when vision is not improved to normal limits by the wearing of glasses/contact lenses.**

**If you are considering making a referral to the Vision Support Team, the child/young person must have a diagnosed vision impairment or be experiencing significant visual difficulties and under assessment at a Hospital Ophthalmology Department.**

**To support the referral process please return this form with the following documents:**

* Parental consent
* Letter confirming CYP’s involvement with an Ophthalmology department and/or vision diagnosis from a medical professional (Ophthalmologist/paediatrician/GP)

**Please email completed forms to-** **VSTReferrals@birmingham.gov.uk**

|  |
| --- |
| **Personal Details of Child/Young Person** |
| Forename:        |  Surname:        | Preferred name:       |
| Date of Birth:       | Gender:        |
| Year Group:       | Preferred language:       |
| Child Protection Plan Y/N Child in Need Plan Y/N Looked after child Y/NSocial worker details (if applicable) : |
| EHC Plan: Y/N SSPP Plan Y/N EY Plan Y/N |
| **Parent/Carer Details** |
| Forename:       | Surname:       |
| Relationship to Child:       | Parental responsibility: Yes [ ]   |
| Is an interpreter needed?: Y/N If yes, which language?       |
| Home Address:       |
| Tel No:       | Email:       |
| **School/Setting Details** |
| School/Setting name:  | Tel No:       |
| Address:       |
| SENCO Name and contact email address:       |
| Alternative Name, role and contact email address:       |
| SENCO Working Days (please highlight): |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mon | Tues | Wed | Thurs | Fri |
| am | pm | am | pm | am | pm | am | pm | am | pm |

 |
|  |
| **Referrral Information** |
| Details of vision condition/diagnosis: |
| Ophthalmology clinic details: |
| Visual measurements (from Ophthalmology): |
| Glasses/contact lenses worn: |
| Main areas of concern around vision: |
| Details of any additional/medical needs: |
|  |
| Please give details of all other educational agencies involved (e.g. PDSS, EP, PSS, HST, CAT) |
| Name | Agency | Contact Details |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Please give details of medical professionals involved in addition to Opthalmology- if known (e.g. Hospital Consultants, Physiotherapist) Please enter names with contact details below |
| Name | Agency | Contact Details |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |

**Vision Support Team**

**VSTReferrals@birmingham.gov.uk**

click on the link below to access Vision Support Team information on Birmingham Local Offer website

[**Sensory Support Vision | Local Offer Birmingham**](https://www.localofferbirmingham.co.uk/send_support_services_menu/sensory-support/)