**A picture containing text, design, logo, graphics

Description automatically generated**

**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**](mailto: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/N  Social 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**](mailto: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/)