**Visual Processing Clinic Referral ( Orthoptist )**

**Please note:** **A child must initially be seen by an optician before a referral can be made. Minimum age for referral is 7 years.**

**NAME OF CHILD:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**M/F**\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHOOL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHOOL ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last sight test ----------------------------------------**this must be within the last 6 months**

Does the child / young person display signs of the following :

Skipping words / lines ? YES/ NO

Page blurring / words moving / visual disturbances? YES/ NO

Finger tracking ( child aged > 8 yrs )? YES/ NO

Slow reading speed? YES/ NO

Previous use of overlay? YES/ NO

Sequencing difficulties / confusing letter order in words / substituting

Visually similar words? YES/ NO

Any other information?

Parents/ guardians are aware of this referral and agree to an assessment being carried

out and the results being shared with relevant professionals.

**Signed:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/ Guardian

------------------------------------------------------------------------ SENCO

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------------------------------------------------------------------------ Print SENCO Name

Date \_\_\_\_\_\_\_\_\_\_\_

Site to be seen ( *please delete* ) : Lincoln / Boston / Spalding / Grantham

**Please email form to:**  **NewAppointmentsHNT@ULH.nhs.uk**