**ST HELENS & KNOWSLEY TEACHING HOSPITALS NHS TRUST**

**REFERRAL TO OPHTHALMOLOGY/ ORTHOPTIC CLINIC-CHILDREN’S SERVICE**

Please complete **all** sections of the form and send to sthk.orthopticservices@nhs.net forms that have not been completed in full, will be returned.

|  |
| --- |
| **Patient Details** |
| Patient name: |  |
| Patient DOB: |  |
| Address: |  |
| Postcode: |  | NHS number: |  |
| Parent/ Guardian:  |  | Telephone number: |  |
| GP: |  |
| Local Clinic:  |  |

|  |
| --- |
| **Reason for referral and relevant information:** |
| Visual acuity: | Right eye: |  | Left eye: |  | Test used: |  |
| Squint YES / NO: |  |
| Other reason: |  |

|  |
| --- |
| **Refers details:** |
| Referral date  |  | Signed: |  |
| Name : |  |
| Email:  |  | Telephone number: |  |
| Designation:  |  | Base: |  |

|  |  |
| --- | --- |
| Interpreter required for appointment: Yes/No  |  |
| Language/ BSL (British sign language) |  |

**Parent/Guardian to sign**

I agree to my child’s referral for the Ophthalmology/ Orthoptic Clinic-Children’s service:

Verbal:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/ Guardian