

**Orthoptic Specific Learning Difficulty Clinic Referral Form- Optician/ Health Care Professional**

In order for us to gain a full picture of your child’s difficulties, we ask for parents to complete the attached questionnaire. Please pass this form back to your optician so it can be attached to your child’s referral letter. Upon receipt of the referral letter, and this form, an appointment for the child will be arranged. Please note, incomplete forms will delay this process. We only accept referrals for children over the age of 7 and that are of reading ability.

**Child’s Name: DOB: Gender:**

**Child’s Address:**

**Parent/Guardian Name:**

**Parent/Guardian Telephone Number:**

**GP**

**School:**

**Signs and Symptoms (please tick):**

Eyes

* Red eyes/ watery eyes or eyelids when reading
* Rubs eyes frequently
* Closing/covering one eye in bright light or when reading/writing
* Complaining of headaches or pain round eyes when reading
* Unusual fatigue following reading
* One eye turning in, out, up or down

Reading /writing

* Complains of blurred vision during reading or writing
* Complains of seeing double
* Avoids close work
* Holds books very close
* Holds books far away
* Tilts head when reading/writing
* Moves head when reading
* Skips or re-reads words/ lines
* Adds in words
* Has difficulty staying on the same line
* Uses their finger or reads with a ruler
* Complains of print jumbling
* Poor ability to remember what they have read
* Poor understanding of what they have read
* Mistakes words with the same beginning or ending e.g. can/cat
* Fails to recognise the same word in the next sentence

Visual perception

* Difficult following verbal instructions
* Short attention span, easily distracted
* Has difficulty remembering anything in sequence order e.g. days of the week or timetables
* Struggles to copy from the board
* Transposes letters or numbers
* Confuses right-left directions
* Difficulty identifying objects in a crowded environment

Writing

* Poor pencil grip
* Poor hand-eye coordination
* Poor handwriting
* Poor standard of written work compared to oral ability
* Poor spelling

Previous Eye Problems

Has your child been seen by the Orthoptist or Optician before? YES/NO

If yes, what treatment have they had?

Does your child have glasses? YES/NO

General Health

Does your child have any health issues? YES/NO

If yes, please state

Does your child take any regular medication? YES/NOHea

If yes, please state

Does your child have any allergies? YES/NO

If yes, please state

Has your child ever been seen by any other health professional? For example, an occupational therapist, Speech and Language Therapist, Audiologist, Physiotherapist, Paediatrician or Dietitian. YES/NO

If yes, please state who and when

Does your son/daughter have a healthy balanced diet including food rich in Omega 3 (e.g. oily fish, broccoli and vegetables)? YES/NO

Does your child have a good sleep pattern? YES/NO

Birth History

Was your child born full term? YES/NO

Was it a normal delivery? YES/NO

What was their birth weight?

Family History

Is there family history of eye problems such as a lazy eye, glasses or a turn in the eye? YES/NO

If yes, please state

Is there any family history of Learning Difficulties like dyslexia? Or attention/ hyperactivity disorder (ADHD or ADD)? YES/NO

If yes, please state

Fine motor skills

Does your child have good fine motor skills? For example, can/did they manage buttons, zips and laces, dress/undress, able to use knife and fork and scissors (appropriate to age). YES/NO

If not, please state

Does your child hold a pencil correctly? YES/NO

Additional Comments

I give consent for my child to be referred to the Orthoptic Services Specific Learning Difficulties Clinic and I am aware of the reasons for this referral.

Signed: Parent/Guardian Date

Referred by: Designation:

Referrer Signature:

SpLD Clinic

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