**Children’s Community Eye Service (CCES) Referral Form**

**Integrated services for Children with Additional Needs (ICAN)**

**Thank you for completing all sections of the referral form.**

 **Incomplete referrals may be returned.**

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| **CHILD/YOUNG PERSON DETAILS** |
| **Name of child/young person** | **Is an Interpreter Required?****Yes □****No □****If Yes - Please state language required** |
| **Date of Birth** | **NHS Number** |
| **Age of child/young person** | **Male/Female** | **School/Nursery/Children’s Centre Details** |
| **Address** |
| **Postcode** | **GP/Family Doctor Name and Contact Number** |
| **Telephone Number** | **Health Visitor/School Nurse Name and Contact Number** |
| **Mobile Telephone Number**  | **Any Other Professionals Names and Contact Numbers** |
| **Email address** |  |
| **Parent/Carer Consent obtained this referral?****Yes □** **No □**  | **Self-Consent obtained for this referral?****Yes □** **No □**  |
| **Will the family have difficulty contacting us to choose and book an appointment?** **Yes □** **No □**  | **How does the family prefer to be contacted?****□ Telephone****□ Letter**  |
| **Are there any Safeguarding Concerns regarding this child/family?****Yes □** **No □**  | **Parent/Carer Consent to receive text reminder message****Yes □** **No □**  |
| **Height** | **Centile** | **Weight** | **Centile** |
| **REFERRING CLINICAL PRACTITIONER DETAILS** |
| **Name of person completing this form ►** |  |
| **Title of referrer** |  |
| **Address** |  |
| **Telephone Number / Email address**  |  |
| **Date of referral**  |  |

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| **Referral Reason – Please select as appropriate** |
| **Reduced Vision □** **Squint □** **Ptosis □** **Unequal Pupils □** **Colour Vision Defect □**  | **Parental Concern □** **Family History □** **Other □**  |
| **(please state if different)** |
| **Right** | **Left** | **Test Used – Crowded LogMAR (please state if different)** | **Has the child got very dark brown eyes?****Yes □** **No □** |
| **The completed referral should be sent to ICAN Services by one of the following methods:** |
| **By SystmOne task once referral has been added to communications and letters, ideally using the ICAN referral form template:****To sys1 unit “Leeds Community Child Health Services”, task group “Central Referral Management Tm”, task type - ideally with some reference that a referral is being made****PLEASE DO NOT SEND E-REFERRALS TO THE CHILD HEALTH UNIT DIRECTLY** |
| **By email: ican.referrals@nhs.net** |
| **By Post:** **The Referral Management Centre****Integrated services for Children with Additional Needs****3rd Floor Stockdale House****Victoria Road****Leeds****LS6 1PF** |
| **Telephone enquiries to: 0113 843 3620** |