**Cause for Concern Orthoptic Referral**

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| **Patient details** | | **NHS number:** |  |
| **Surname:** |  | **Forename:** |  |
| **DOB:** |  | **GP:** |  |
| **Address:** |  | **Home Telephone:** |  |
|  |  | **Patient mobile:** |  |
| **Post Code:** |  | **Own transport** | **Yes  No** |
| **Referrer name:** |  | **Date of referral:** |  |
| **Designation:** | Health Visitor GP Community Paediatrician School Nurse Other | | |
| **HV name:** |  | **HV team:** |  |

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| **Parent consent for referral (Y/N):** |
| **Preferred appointment (clinic / time / day etc.)** |

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| **Ocular symptoms** (please mark with a ✓) | | | | **Ocular signs** (please mark with a ✓) | | | |
| Esotropia |  | Exotropia |  | Other Squint |  | Ptosis (lid droop) |  |
| Blurred vision |  | Family concerns |  | Defective eye movements |  | Abnormal pupils |  |
| Nystagmus (wobbling eyes) |  | Closing one eye |  | Misjudging distance |  | Other (please add details below) |  |

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| **Additional information:** |

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| **General Health** | **Family History** | |
| Note any known pre-existing conditions: | Note any childhood eye conditions: | |
| **Please e-mail referral for the attention of Orthoptic Department to :**  [hyp-tr.cfcorthoptichey@nhs.net](mailto:hyp-tr.cfcorthoptichey@nhs.net) | |