**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** [x]  |
| **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 |