WITH MY EYES Referral Form

**CHILD**

Name:

Date of Birth:

Address:

Emergency Contact Details (name and number):

Reason for Referral:

Please state any additional support currently received:

Name and telephone number of GP practice:

Please state any allergies or important medical information (E.g. asthma):

Please state any other information that may be relevant (E.g. received DT/ counselling previously):

In an ideal world what would be the desired outcome from the sessions?

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**PARENT/GUARDIAN**

Please give as much information as possible. Answers should be separate to those given for the child.

Name:

Date of Birth:

Address:

Emergency Contact Details (name and number of someone who will not be attending the sessions):

Reason for Referral:

Please state any additional support currently received:

Name and telephone number of GP practice:

Please state any allergies or important medical information (E.g. asthma):

Please state any other information that may be relevant (E.g. received DT/ counselling previously):

In an ideal world what would be the desired outcome from the sessions?

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**REFERRER**

Name

Position and Organisation:

Contact Details:

How did you hear about *With My Eyes*?

FURTHER INFORMATION

**It may be necessary to contact the child and their parent/guardian from time to time – with details of sessions etc. What is the preferred method of contact?**

**Please add any other comments here:**

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