WITH MY EYES Referral Form

**CHILD**

*Please give as much information as possible.*

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?

**PARENT/GUARDIAN**

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

Name:

Date of Birth:

Address:

Mobile Number:

Email 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?

**REFERRER**

Name:

Position and Organisation:

Phone:

Email:

How did you hear about *With My Eyes*?

**What is the preferred method of contact with the participants?**

**Please add any other comments here:**