Vision support referral form

Before completing this form, this referral **must** be discussed with parent/carer who **must** sign the form (this person is referred to as “family contact”)

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| Pupil Name: **Gender:** Male / Female | **Date of Birth:** |
| **Address:** | Family Contact: **Telephone No.:**  **Email address (*essential*):** |
| **Home Language(s):** | Interpreter needed?For parent/carer(s): Yes/NoFor pupil: Yes/No |
| **School:**  **Year Group:**  **Contact Person:**  **Role:** | **At which stage of the SEND Code of Practice:** *(Please circle)*   * SEN Support * EHC Plan   If EHC Plan - date of Issue: |
| **Ethnicity** *(please tick)***:**   |  |  |  |  | | --- | --- | --- | --- | | **White** - British | **Mixed** - White and Black  Caribbean | **Asian** – Asian British/  Indian | **Black** - African | | **White** - Irish | **Mixed** - White and Black  African | **Asian** – Asian British/  Pakistani | **Black** – Black British/  Caribbean | | **White** – Other white | **Mixed** - White and Asian | **Asian** – Asian British/ Bangladeshi | **Black** – Other Black | | **Travellers White** – Gypsy/  Roma | **Mixed** – Any Other Mixed  Background | **Asian** – Asian British/  Any Asian Background | **Any other ethnic group** | | **Travellers White** – Traveller  of Irish Heritage |  | **Chinese** |  | | |
| **Nature of visual impairment/cause of concern:** | |
| **Medical Information:**  **Hospital . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Consultant . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**  **Hospital Number . . . . . . . . . . . . . . . . . . . . . . Other medical conditions, if any. . . . . .. . . . . . . . . . . . . . .. . . . . . . . . . . . . .**  **Is the pupil registered severely sight impaired (SSI) / sight impaired (SI) *(please circle)*** | |

**What other agencies have been involved with the child?**

* Occupational Therapy Physiotherapy Speech & Language Therapy
* Hearing Support Child & Adolescent Mental Health Youth Offending Team
* Social Services Behaviour Support Team Education Welfare
* Other *(please specify):*

*Parent / Carer’s Section*

Agreement for Haringey’s Sensory Team involvement

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| Name of Family Contact: |
| Relationship to Child: |
| Is the family contact in agreement with this referral: YES / NO |
| Signature of Family Contact:  Signature . . . . . . . . . . . . . . . . . . . . . . . . . . ………………….. Date . . . . . . . . . . . . . . . . . . |
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***Data Protection Act 2018 Right to be Informed - Privacy Notice:***

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| Organisation collecting your information | Haringey Council’s Record of Processing Activities sets out full details of why and how we use personal information. You have a right to access the information that we hold and have inaccurate information corrected. Please see the information on the [Data Protection](http://www.haringey.gov.uk/contact/information-requests/data-protection) section of our website for details of our processing activities, your legal rights relating to how we use your personal data and how to exercise those rights. |
| Why we need your personal information | To oversee and manage the sensory support services provided to you by Haringey Council |
| Data Protection Act 2018 basis for processing | Processing is necessary for compliance with a legal obligation |
| Details of statutory or contractual obligation | Children and Families Act 2014 (section 3), Education Act 1996 |
| Consequences of not providing the information | Example: Haringey council would be unable to investigate or respond to your complaint. |
| Who we might share your information with | Haringey Officers, DfE and Other professionals if required, schools, colleges, preschool settings, health, other professionals, other local authorities where necessary. |
| How long we will keep your information | 25 years from DOB |

**Please send to:**

Sensory Support Team - Vision

Haringey Council,

Children’s Services, 5th Floor, 48 Station Road, Wood Green, N22 7TY

Email: [sensorysupport@haringey.gov.uk](mailto:sensorysupport@haringey.gov.uk)