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”)

|  |  |
| --- | --- |
| 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

|  |
| --- |
| Name of Family Contact: |
| Relationship to Child: |
| Is the family contact in agreement with this referral: YES / NO |
| Signature of Family Contact:Signature . . . . . . . . . . . . . . . . . . . . . . . . . . ………………….. Date . . . . . . . . . . . . . . . . . .  |
|  |

***Data Protection Act 2018 Right to be Informed - Privacy Notice:***

|  |  |
| --- | --- |
| 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