

**Visual Impairment Inclusion Support Service**

**Hazelwood School**

50 Dumbreck Court

Glasgow G41 5DQ

**Phone 0141 427 9334**

Fax 0141 427 2859

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| **Visual Impairment Inclusion Support Service Referral Form** | | | | |
| **Referral Details** | | | | |
| Name of person making referral: |  | | | |
| Date of referral: |  | | | |
| Name of organisation or relationship to child/young person: |  | | | |
| Contact details: |  | | | |
| **Child/Young person details** | | | | |
| Name: |  | | | |
| DoB: |  | | | |
| Address. |  | | Tel no: |  |
| School: |  | | Tel no: |  |
| Eye condition: |  | | | |
| Ophthalmologist:  CHI number (If known) |  | | | |
| Details of how eye  condition impacts  on access to education: |  | | | |
| Details of any other factors impacting access to education e.g. ASD, Dyslexia, Cerebral Palsy, English as an Additional Language |  | | | |
| Parent/carer’s permission for VI Teacher to seek information from hospital regarding child’s vision. | Signature ……………………………………………………… | | | |
| **For VIISS Use Only** | | | | |
| Date referral received: | |  | | |
| Teacher Assigned: | |  | | |
| Date of initial assessment: | |  | | |

Please return to the address at the top of the form or e mail to [Headteacher@hazelwood.glasgow.sch.uk](mailto:Headteacher@hazelwood.glasgow.sch.uk)