***Croydon Sensory Support Service***

**REFERRAL REQUEST**

Please tick the box(es) for the services you are referring to:

Hearing

Vision

**Baby/Child/Student Details**

|  |  |
| --- | --- |
| First Name:  | Family Name: |
| Date of Birth:  | Gender: Male [ ]  Female [ ]   |
| Ethnicity: | Language(s) spoken at home: |
| Address: |
| Educational Placement: |

**Parent/Carer Details**

|  |
| --- |
| 1. Parent / Carer name:
 |
| Relationship to child or young person: |
| Parental responsibility? Yes [ ]  / No [ ]  |
| Address: |
| Daytime telephone number:  | Mobile Number: |
| Email address: |

|  |
| --- |
| 1. Parent / Carer name:
 |
| Relationship to child or young person: |
| Parental responsibility? Yes [ ]  / No [ ]  |
| Address: |
| Daytime telephone number: | Mobile Number: |
| Email address: |

**Reason for Referral**

|  |
| --- |
| **Details of Hearing/Vision**(please attach most recent audiogram/clinic letter) |
| **Hearing aids/glasses/other prescribed?** Yes [ ]  No [ ] **Details:** |
| Name of Hospital/Clinic: | Hospital Number: |
| Name of Consultant: |
| Other professionals involved: |

**Referral made by**

|  |
| --- |
| Name of person making this referral: |
| Designation: |
| Signed: | Date: |

**Parent/Carer Consent**

For reference, the Croydon Education & Youth Engagement department privacy notice can be viewed at[**https://www.croydon.gov.uk/democracy/data-protection-freedom-information/privacy-notices/education-youth-engagement-service-privacy-notice**](https://www.croydon.gov.uk/democracy/data-protection-freedom-information/privacy-notices/education-youth-engagement-service-privacy-notice)

|  |
| --- |
| **I hereby give consent for:**The Croydon Sensory Support Service to contact my child’s hospital for information about his/her hearing/vision: Yes [ ]  No [ ] The Croydon Sensory Support Service to contact my child’s school regarding his/her hearing/vision: Yes [ ]  No [ ] The Croydon Sensory Support Service to share information with other relevant health and education professionals: Yes [ ]  No [ ] The Croydon Sensory Support Service to hold and use personal contact information to contact me about my child. The service will not share this contact information without your explicit consent: Yes [ ]  No [ ] **Parent/Carer signature ………………………………………****(or student if 16+)** **Please print name ……………………………………………….** |

**Please complete in consultation with parent/carer and return to:**

Croydon Sensory Support Service, 90 Central Parade (Area Office), New Addington, Croydon, CR0 0JB

Tel: 0208 760 5783 Email: sensorysupportservice@croydon.gov.uk

***You are able to withdraw your consent for provision of services from CSSS at any time by using the contact details above.***