 SEND Services for *your* School

***SASC Visual Difficulties Screening Protocol***

**Learning Support Team**

**Visual History Questionnaire**

**To be completed by Parent/Carer**

|  |  |
| --- | --- |
| **Pupil’s First Name** |  |
| **Pupil Surname** |  |
| **Pupil’s Date of Birth** |  |
| **School Name:** |  |
| **Date form completed (DD/MM/YYYY)** |  |
| **Name of Parent/Carer completing the form** |  |

In accordance with SASC guidance, specialist teachers must conduct screening for visual difficulties prior to an assessment. Where concerns are identified, a referral for further professional assessment, such as by an optometrist, should be made. This step ensures that any visual factors impacting learning are identified and managed prior to us completing the full diagnostic assessment.

While visual difficulties are not a symptom of dyslexia, they can cooccur and impact a learner's ability to engage with text. Recognition of visual symptoms is a starting point for the identification of visual difficulties that may require treatment.

|  |  |  |
| --- | --- | --- |
| Please answer the following questions, where appropriate. | | |
| Has the child been prescribed and advised to wear any optical prescription lenses (glasses or contact lenses)? | YES / NO | Please provide details: |
| Are these required for distance vision (e.g. television), near vision (e.g. reading) or both? | Distance  Near  Both | If glasses/contact lenses are worn for near work  (e.g. reading and writing), then they need to be worn for the SpLD assessment. The assessment may be cancelled on the day if this requirement is not fulfilled. |
| Does the child wear their glasses/contact lenses as advised? | YES / NO |  |
| How long ago was the child’s last eye test carried out by an optometrist (optician)? | Less than 2 years ago  More than 2 years ago  Never | If the child has **NOT** had an eye-test carried out by an optometrist within the last two years, then a test is required. |
| Has the child ever used coloured overlays or precision-tinted lenses? | YES / NO |  |
| If YES then:  who recommended and provided the overlay/precision-tinted lenses?  Why were they recommended?  Did they help?  Are they still used? | YES / NO  YES / NO |  |
| Has the chid ever had hospital treatment for a problem with their eyes or vision?  FOR EXAMPLE:  wearing a patch for a ‘lazy eye’ (amblyopia)?  or  wearing glasses or having exercises to help correct a ‘turn’ in the eye (squint)  or any other condition? | YES / NO | Please provide details of the treatment and when it took place. |

**Please continue and complete the Visual Difficulties Questionnaire.**

**If a response of ‘YES’ is given to any of the questions 1-10 then referral to an optometrist for further assessment is required, regardless of whether there is recent history of a sight-test.**

**The optometrist should be asked to provide a full assessment of eye health and visual function. This should include the ability of the eyes to focus and work together correctly (binocular accommodation and convergence) which should form part of a standard NHS eye test.**

**A copy of this questionnaire can be given to the optometrist for their information.**

For advice and support please contact SEND Services for *your S*chool

Tel: 01527 87722 email: schoolsupportservices@chadsgrove.worcs.sch.uk

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***SASC Visual Difficulties Screening Protocol***

**Learning Support**

**Visual Difficulties Questionnaire (VDQ)**

The VDQ requests simple yes/no answers to a few questions about symptoms and signs involving FEEL (visual discomfort, Q1-3), SEE (visual disturbance Q4-7, DO (behaviour Q8-9), and one general question 910) about any other experience.

**If a response of ‘YES’ is given to questions 1-10 then referral to an optometrist for further assessment is required, even if there is history of a recent eye test.**

|  |  |  |
| --- | --- | --- |
| QUESTION | NO | YES |
| **OFTEN** = persistent, occurring several times a week, though not necessarily, every day.  Please answer ‘NO’ if the reported symptoms would be considered infrequent (e.g. rarely, occasionally, sometimes or less than 2-3 times per month). | | |
| 1. Does the child **often** get headaches when they read or study? |  |  |
| 1. Does the child’s eyes **often** feel sore, or gritty, or watery? |  |  |
| 1. Does reading from white paper or from a bright screen **often** feel uncomfortable? |  |  |
| 1. Does print **often** appear blurred, or go in and out of focus, when they are reading? |  |  |
| 1. Does the print, or book, or screen, **often** appear double when they are reading? |  |  |
| 1. Do words **often** seem to move or merge together when they are reading? |  |  |
| 1. Do objects in the distance **often** appear blurred after they have been reading? |  |  |
| 1. Do they **often** have to screw up their eyes to see more clearly when they are reading? |  |  |
| 1. Do they **often** move their eyes around or blink to make things clearer or more comfortable when they are reading? |  |  |
| 1. Do they experience any other problems with their vision that interfere with their ability to read or study?   If YES, then please describe: |  |  |

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