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| **Name of Clinic or Clinical Pathway** | Children’s Community Eye Service (CCES) |
| **Narrative description of the clinic or clinical pathway** (no more than 50 words) | The CCES provides care to children between the ages of 6 months and 8 years who have a Leeds GP. We also provide care for older children who have special needs or learning difficultiesIf a referrals is received for a child over 8 years old they should task Tess Garretty for triage.Children referred into the service by the Leeds school screening programme should also be accepted. |
| **Who can refer?** | * School Nursing
* Health Visitors
* GP’s
* Community Paediatricians
* General Optometry Service
 |
| **Who can’t refer?** | *Insert in bullet form* |
| **What intervention is expected by the referrer before a referral is made?** | The CCES leads a vision screening service in Leeds that is delivered by the school nursing team. All children are offered a vision test in school at the age of 5. The CCES also delivers vision screening for 5 year olds in special schools  |
| **Referral Criteria** |  |
| **Inclusions** | **Presenting Symptoms** | **Exclusions (including referral route)** |
| Vision defectsMisalignment (squints)Eye movement disorders | *Insert in bullet form* | *Referrals to the Hospital Eye Service should be made for:** Watery eyes / recurrent eye infections
* Suspected conjenital cataracts
* Cysts / styes
 |
| **Referral Criteria 2** (if more than one referral route/clinic option – add more sections as required) |
| **Inclusions** | **Presenting Symptoms** | **Exclusions (including referral route)** |
| *Insert in bullet form* | *Insert in bullet form* | *Insert in bullet form* |

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| **Role of other professionals in the pathway** (if applicable) |
| **Profession** | **Key Responsibilities** |
| Orthoptists | * *Triage referrals*
* *Undertake initial assessment of vision, binocular vision, eye movements*
* *Form diagnosis*
* *Initiate management as required*
* *Refer to Hospital Eye Service as required*
 |
| Optometrists | *Insert in bullet form** Undertake refraction
* Undertake fundoscopy
* Prescribe spectacles as required
* Refer to Hospital Eye Service as required
 |
| **Referral to other services** (if applicable) |
| **Name of Service** | **Reason for Referral** |
| Paediatric Ophthalmology service at St James’ Hospital | *Insert in bullet form** Suspected pathology
* Amblyopia not responding to treatment
* Atropine occlusion therapy
* Squint surger
 |
|  | *Insert in bullet form* |
|  | *Insert in bullet form* |

* Version control section to be added at the end
* May include decision making tree as an appendix