TRAINING MANUAL AND OPERATIONAL PROTOCOLS FOR SCHOOL NURSE VISION SCREENING

Produced regionally by Orthoptists in consultation with Community Nursing, Paediatric Ophthalmology, Paediatric Optometry, and Education Providers

Date implemented: 3 September 2020
Reviewed: September 2024
Date of next review: September 2027

HSC Public Health Agency

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1. Introduction

Amblyopia, strabismus and significant refractive error are the most prevalent vision disorders of childhood and occur with predictable frequency in around 10% of children. There is clinical evidence that children with these conditions benefit from early detection to optimise the potential of a successful treatment outcome[1]. Treatment during the critical period of visual maturation allows optimal management of affected children.

The UK **National Screening Committee (NSC)** recommends[2] that screening for visual impairment should be offered to all children aged 4-5 years and that this screening service should be organised and led by Orthoptists. The test for use at the age of 4-5 years is the Keeler Crowded logMar Test[3] as recommended by the British and Irish Orthoptic Society[4]. The NSC further states that 'All children with a visual acuity less than 0.20 logMAR on the Keeler crowded logMAR test in one or both eyes are referred on for assessment'[5][6].

The implementation of a Northern Ireland Orthoptic-led Regional Vision Screening Programme supports the principles within the **Healthy Child, Healthy Future** 2010 document[7]. This document recommends that all children in Northern Ireland between the age of 4 and 5 years undergo vision screening. This guidance is in line with the recommendations of the **National Screening Committee (2019),** the **Royal College of Ophthalmology**, and **Health for All Children** (Emond, 2019[8]) and form the basis for Orthoptic training for School Nurses.

This guidance also forms the basis of vision screening training for School Nurses which will be delivered as part of their initial training within the University of Ulster Specialist Community Public Health Nursing course, who will engage the professional support of Regional Orthoptics services to ensure all training is Orthoptic-led. Staff should attend mandatory updates on a three-yearly basis which will be organised locally within Trusts. Additional one-to-one practical support can be accessed through the Line Manager and local Orthoptic Department and School Nurses are offered the opportunity to enhance their experience by attending an Orthoptic clinic.

This document will be reviewed every 3 years.

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[1] Rahi, J., 2017, Advice on Commissioning of Ophthalmic Services for Children Visual Impairment, Eye Conditions and Commissioning, available from https://www.rcophth.ac.uk

[2] https://www.gov.uk/government/publications/child-vision-screening

[3] Stewart C. LogMar-based visual acuity measurements: limits of normality; Br Ir Orthopt J 2006;3:9-13

[4] Emond, A. (ed.), 2019, Health for All Children, Fifth Edition, p 254

[5] https://www.gov.uk/government/publications/child-vision-screening/service-specification

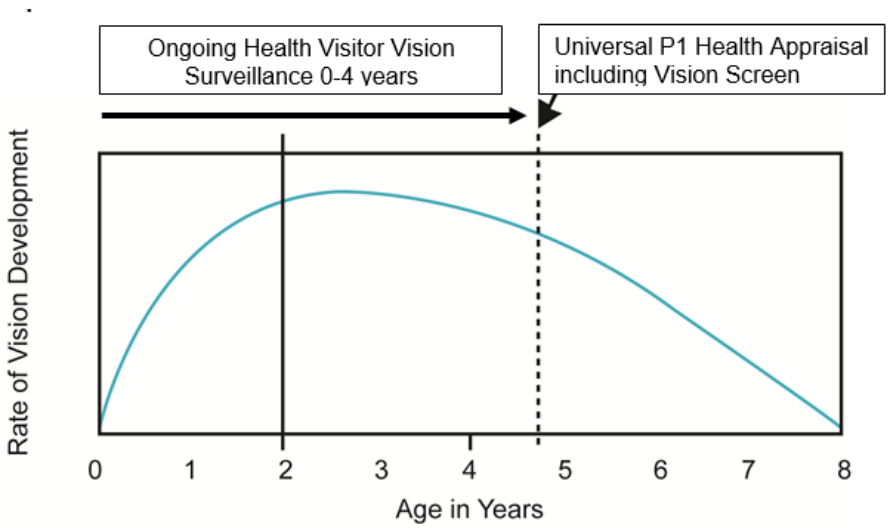
[6] National Screening Committee, 2019, https://legacyscreening.phe.org.uk/vision-child

[7] Healthy Child, Healthy Future May 2010. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/healthychildhealthyfuture.pdf

[8] Emond, A (ed.), 2019, Health for All Children 5th Edition, RCPCH

2. What is normal visual development?

The critical period for visual development and emmetropisation (i.e. normalisation of refractive error) is from birth until about 7-8 years of age when vision reaches maturity. During this period if a child has an uncorrected refractive error (or certain types of strabismus) vision fails to develop to normal levels. Children may appear to function very well and may seem visually normal despite the need for glasses or when an amblyopic/lazy eye is present. Therefore, it is essential when testing vision to ensure that the covered eye is occluded properly.



Visual Perception

Visual perception comprises of 3 parts:

1.Light perception:	The most primitive of the three, the ability to distinguish between light and dark.
2. Form perception:	The ability to distinguish the size and shape of objects.
3. Colour perception:	The ability to distinguish between different colours

Most Common disorders of vision:

Refractive error This is the presence of an error in the optical or 'refractive' system of the eye and leads to a blurred image being formed on the retina. Types of refractive error are:

- Hypermetropia (long-sightedness)
- Myopia (short-sightedness)
- Astigmatism ("rugby ball-shaped eyes")

	In order to give a clear image on the retina, glasses are prescribed for full-time wear.
Amblyopia	Sometimes called lazy eye. This is the reduction of Visual Acuity (or "corrected vision" i.e. where a refractive error is corrected) which is not the result of any clinical/pathological anomaly of the visual pathway (e.g. cataract, nystagmus, etc.). Amblyopia is not relieved by correcting any refractive error (i.e. putting on glasses).
Strabismus	(Also known as squint) The presence of strabismus or a squint can be a cause of amblyopia because the fovea (the point on the retina where critical and best vision is achieved) is not being stimulated correctly.

Visual development occurs from birth to approximately 7-8 years of age; therefore, early detection of all types of visual problems is essential if treatment is to be successful.

3. Overall Vision Screening/Surveillance Pathway from Birth to P1 Health Appraisal

Time of contact	Person responsible	Assessment
72 hours	Maternity Staff	**Newborn vision screening protocol** All babies, irrespective of gestational age, receive a red reflex check prior to discharge from hospital postnatal ward or Neonatal Intensive Care Unit and again at eight weeks by GP. The Retinopathy of Prematurity (RoP) screening pathway is followed for all preterm babies and treatment planned if required.
8 weeks	GP visit	GP eye assessment (including red reflex)
0-4 years	Health Visitor	Ongoing vision surveillance as part of routine health visiting contacts (no formal vision screening protocol). Children are referred to the Orthoptic service if required.
P1 Health Appraisal	School Nurse	Vision screening completed as part of universal P1 Health Appraisal programme in accordance with NSC recommendations.

All babies, irrespective of gestational age, receive a red reflex check prior to discharge from hospital postnatal ward or Neonatal Intensive Care Unit, and again at 8 weeks by GP.

The Retinopathy of Prematurity (RoP) screening pathway is followed for all preterm babies and treatment planned if required.

Retinopathy of prematurity (ROP) is a potentially sight threatening condition which affects a proportion of preterm babies and very low birth weight babies. Early detection and treatment can prevent vision loss therefore ROP screening is carried out for every infant born at:

- less than 32 weeks gestational age (i.e. up to 31 weeks and 6 days) **or**
- less than 1501 grams birth weight.

Following discharge from hospital and routine GP visit, Health Visitors carry out ongoing surveillance and monitoring of vision as part of their regular routine visits, including the 2-year review and 3+ year preschool review. This surveillance includes monitoring of risk factors, family history, parental concerns and professional observation of visual development, and if required children are referred to their local Orthoptic service.

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1. Vision Testing

Who to test?

As part of Primary 1 Health Appraisal, **all** children aged 4 or 5 years (during their Primary 1 school year) for whom consent for a health appraisal has been obtained, including:

- Children who already attend Orthoptist
- Children who already attend Optometrist
- Children who already attend Ophthalmologist
- Children who wear glasses – screening check must take place **ONLY with glasses on**
- Children who are wearing a patch – **check each eye**
- Children with a known eye disorder

Special Schools

In 2020 a regional Orthoptist-led model was implemented across all special schools to meet National Screening Committee (NSC) recommendations. This model entails a full vision assessment in addition to the vision screening required in the P1 Health Appraisal.

Consent

NB: Consent must be obtained from the person with parental responsibility for the child, prior to screening.

Incomplete Screening

Guidance is that all children should undergo vision screening between the ages of 4-5 years.

- If a child (with consent) is absent for the vision screening, a recall is offered within their P1 academic year.
- If the consent form is not returned, a recall (contact parent) is offered within the P1 academic year.
- Following a non-return of two consent forms, or if the consent form is returned with “declined” - contact parent to reinforce importance of universal screen.

If a child has not been screened by the beginning of their P2 academic year and consent has been received they should be referred to the Orthoptist using the agreed referral forms. The parent must be consulted in relation to this referral and separate consent obtained.

‘Movement-In’ Children

When School Nurses are informed of movement-in children of primary school age they should review the child health record, and if vision screening has not been previously recorded and consent for a health appraisal has been received, vision screening should be completed for these children. Referral should be made to the Orthoptic Service if required as per the standard referral pathway.

Deferred Entry to P1

Children who have deferred entry to P1 may have a delay in vision screening completed as part of the P1 Health Appraisal. Vision screening should be prioritised for these children in the first term following School entry.

2. Vision Testing Equipment

1. 3m **crowded** LogMar vision test
2. Demonstration/Key Card
3. Recommended Opaque Adhesive Occlusion
4. Measuring Tape
5. CHS Form
6. Regional Parent/Carer Information Letters
7. Regional Orthoptic referral forms

3. Procedure for Assessing and Recording Vision

1. Ensure that consent has been obtained for vision screening.

2. Test the vision of all children for whom consent has been obtained, regardless of whether they are already attending any eyecare professional. This is a Universal Screen and vision needs to be recorded for **each eye** for every child.

3. Note any parental/professional concern or comments which may include the following:

   - Any difficulty reading or seeing the whiteboard or blackboard in the classroom;
   - Any difficulty reading or seeing close work;
   - Squint noticed by anyone;
   - Child has attended or is attending an eyecare professional.

4. Check that the child is able to match or recognise the letters on the vision test using the matching/key card and explain the procedure.

5. For all children with glasses, **test only with the glasses on**. The occlusion must be put on the child's face and the glasses placed on top. Ensure each eye is occluded properly with opaque adhesive tape only, such as Micropore or Durapore, and that the child cannot peep.

6. Test each eye separately.

7. Hold the test so that there is no glare or shadow.

8. Measure an exact 3 metre distance from the test to the child's eye position.

9. Please refer to instruction booklet provided with Keeler Crowded Test for procedure.

10. If the child does not achieve 0.200 LogMAR in each eye they should be referred to the Orthoptic Service and the **actual logMar score should be recorded on the referral form.** If a child wearing glasses does not achieve 0.200 LogMAR in each eye, they should also be referred to the Orthoptic Service.

11. On completion of vision screening, a letter should be sent to all children who have completed screening to advise of either outcome as follows:

    a. Letter to advise parent their child has met NSC standard, **OR**
    b. Letter to advise parent their child has been referred to the Orthoptist.

12. The School Nurse should liaise with their local Orthoptist for any queries or special circumstances.

13. The vision result for each eye should be recorded on CHS.

Good practice when testing vision

It is important when testing vision to ensure that:

- There is adequate lighting – the room should be uniformly bright.
- The testing area is as free from distraction as possible – noise/other children etc.
- The room is of adequate size to allow 3m in a straight line for testing.
- Child's glasses are worn for testing and that they are clean!
- Children wearing a patch for Orthoptic treatment should have their vision tested in each eye.
- Appropriate occlusion worn. Ensure child is not peeping.

4. Referral Pathway

Please refer to the guide below once the vision has been tested.

Screening Result	Comment	Action
Non-compliant / unable to do a crowded LogMAR test		Refer to Orthoptic service with results
LogMAR R:0.200 and L:0.200 or better in each eye	No clinical/professional or parental concerns	Information letter to parent as per overall P1 Health Appraisal protocol
LogMAR R:0.200 and L:0.200	With clinical/professional or parental concerns	Refer to Orthoptic Service with the reason and results
Vision worse than LogMar R:0.200 and L:0.200		Refer to Orthoptic Service with results
Consented child not screened by the end of P1 academic year	A recall should be offered at a second defined time and prior to the start of the next academic year. The recall should not be scheduled too quickly e.g. not within the same week. Should there be an insufficient gap children who are ill, or on holiday toward end of summer terms etc will be missed.	Refer to Orthoptic Service if screening not completed at start of following academic year (separate consent required for referral to Orthoptist)
'Movement-In' children of primary school age with no previous recorded vision screening on CHS	Need to have a vision screen	Follow screening protocol and act on outcomes as per above.
Children who have deferred entry to P1	Need to have a vision screen in first term following entry to school	Follow screening protocol and act on outcomes as per above

5. Referral Protocol

All children who have a suspected vision problem as per the pathway above should be referred to the Orthoptic service using referral forms in line with local Trust procedures.

Parental information about referral

Upon completion of vision screening as part of the P1 Health Appraisal, School Nursing should advise parents of intention to refer to the Orthoptic Service and the reason for this. Appropriate information should be provided to parents regarding the potential risks of not diagnosing or treating early, and the potential consequences if they decline or do not attend the appointment. If parents indicate a preference for a professional known to them (e.g. local optician), explain the different roles of professionals and referral route for different conditions. Referral must be made to the Orthoptics service in any case, and the parent still has the option to decline the Orthoptic appointment when received. Following screening parents will be advised of the outcome of their child's Primary 1 Health Appraisal in any case.

Essential information required on referral form

In order to facilitate the processing of referrals **it is essential to provide all the relevant information** on the appropriate form. Inappropriate and inadequate referrals will be returned to the source in line with Integrated Elective Access Protocols (IEAP) guidelines.

- Date of referral
- Date vision screening completed
- Screening result obtained, including:
    - Test used
    - Acuity: Right Eye, Left Eye, BEO (Both Eyes Open, only if necessary)
    - Screening completed with/without glasses
- Referrer name, designation and contact details
- Who referral has been copied to (person with parental responsibility, orthoptist, child's school health record)
- Please indicate if you consider this to be a priority referral

In addition, please ensure that all of the details listed below are completed:

Parent/carer details:	**Patient details:**	**Referrer details:**
• Name: • Address and postcode*: • Contact no.: • Interpreter Required: • Language: * ensure address on referral letter correlates with admin system/ school	• Name: • DOB: • Gender: • H&C no.: • School: • Known to Social Services • On Child Protection Register • Threshold of need	• Name of HV: • HV Address: • HV Contact no.: • GP address: • GP contact no.: • Date:

records. Incorrect addresses delay child's access to service.	• General Health	

Information to be included in the "Comment" section

- Any relevant medical information, family history if known, and details of any professional and/or parental concerns.
- If the child has been referred without being screened. These children should **only** be referred if there is parental consent and the child has been absent on the days when the school nurse was scheduled to carry out the Health Appraisal.
- Any factors which may influence attendance.
- If the referrer wishes for a copy of the partial booking letter to be copied to either the initial referrer, or to be forwarded to a specific service such as Social Services.
- If a copy of the partial booking letter needs to be copied to any other parties, for example second parent contact (with appropriate consent in place).
- If the child is known to Social Services, is a 'Looked After' child, a child 'at risk' or is on the Child Protection Register. If child is 'Looked After' the name of the carer and relationship to child should be stated on referral.

Providing the above information will ensure that all referrals will be allocated the appropriate clinical priority and prompt access to the service, especially in cases of possible serious visual impairment[9].

What happens after referral?

- The Orthoptist prioritises the clinical urgency of the patient based on the information provided by the referral agent.
- An appointment will be arranged according to clinical prioritisation.
- The GP and School Nurse will be informed of the outcome of initial assessment and proposed treatment.
- When treatment is complete a discharge summary will be sent to the GP.
- At discharge, a letter will be sent to the child's chosen optician. The discharge letter will provided to the family in any case to be taken to any future appointments.
- IEAP (Integrated Elective Access Protocol) guidelines will be adhered to for patients who "Do not attend" (DNA).
- In relation to safeguarding and child protection, each profession must follow the Safeguarding Board of Northern Ireland's (SBNI) Policies and Procedures[10] as well as their own respective professional protocols at all times. Additional information is available via the SBNI website[11].

[9] Emond, A. (ed.), 2019, Health for All Children, Fifth Edition, p 254
[10] Available at: http://www.proceduresonline.com/sbni/
[11] https://www.safeguardingni.org
https://www.safeguardingni.org/aces/home
https://www.safeguardingni.org/neglect

Protocol for discharge

Patients will be discharged from the Orthoptic Department when they meet one or more of the following criteria:

- When maximum potential visual acuity is obtained and maintained over an acceptable period.
- When an assessment of vision and binocular function has been obtained at a satisfactory level.
- Any potential binocularity has been achieved and maximized.
- Acceptable cosmetic appearance.
- Persistent non-compliance with treatment.
- Failure to attend appointments – in accordance with IEAP.
- Self-discharge - if a parent/patient declines treatment or does not wish to attend.
- Patient moved out of the area.

Following discharge, a new episode of care may be initiated, should any further problems arise, by contacting the GP, Optometrist, School Nurse or Orthoptic department.

Appendix 1 – Glossary of Ophthalmic Terms and Conditions

Accommodation	The ability of the eye to focus on near objects. The crystalline lens changes shape to focus the rays of light on the retina.
Alternating strabismus/squint	A squint in which fixation swaps so that each eye is used for fixation, indicating equal visual acuity
Amblyopia	Reduced vision in one or both eyes which may occur due to • Squint (strabismus) • A difference in the lens strength required by each eye (anisometropia) • The need for strong glasses in each eye • Ocular Pathology
Anisometropia	A difference in the strength of lens prescription between the two eyes.
Anophthalmia	A condition that means one or both eyes didn't form during the early stages of pregnancy.
Astigmatism	This is a type of refractive error which results in distorted/blurred vision due to rays of light entering the eye through an irregularly shaped cornea e.g. shaped more like a rugby ball than a football.
Binocular Functions	The ability of the two eyes to co-ordinate together.
Binocular Single Vision (BSV)	When the eyes are straight and used together as a pair to achieve 3D vision.
Brown's Syndrome	An ocular muscle anomaly where the affected eye does not move up and in nasally to its fullest extent. It can be congenital or acquired in one or both eyes.
BSV – Binocular single Vision	See above

Coloboma	A condition where there is a failure of the closure of the optic fissure during foetal development leaving a gap in some or all of the structures of the eye. Usually but not always apparent because the pupil is misshapen e.g. keyhole-shaped. It can occur in different severities.
Compensatory/Abnormal Head Posture	When the head is tilted/turned in a certain direction or the chin is raised up or down in order to compensate for an ocular problem.
Congenital Glaucoma	In congenital glaucoma the eye pressure is higher than normal. This is caused by abnormal drainage of the fluid in the eye. Congenital glaucoma refers to glaucoma which can be either present at birth or appear any time during the first three or four years of life.
Convergence	The ability to pull both eyes inwards maintaining single vision to 6cm/tip of nose.
Convergence Weakness/Insufficiency	The inability to maintain adequate binocular convergence to 6cm. This can cause headaches, blurred or double vision.
Cover Test	This is performed to elicit the presence of manifest squint or latent deviation. The response of each eye is observed as they are covered and uncovered in turn.
Diplopia	Double vision
Duane's Retraction Syndrome	A congenital condition where there is restricted movement of one or both eyes on side gaze.
Eccentric Fixation	A uniocular condition in which a point other than the fovea is used for fixation. Vision is usually poor.
Epicanthus	Skin folds at the inner corner of the eyes.
Esophoria	This is a latent convergent deviation. A slight esophoria is a normal condition.

Esotropia	This is a manifest convergent squint in which one eye turns inwards.
Exophoria	This is a latent divergent deviation. A slight exophoria is a normal condition.
Exotropia	This is a manifest divergent squint in which one eye turns outwards.
Hyper/Hypophoria	This is a latent vertical deviation in which one eye may turn or appear to 'drift' upwards/downwards.
Hyper/Hypotropia	This is a manifest vertical squint in which one eye turns upwards/downwards.
Hypermetropia/Hyperopia	This is a type of refractive error also known as long-sightedness. Rays of light entering the eye come to a focus behind the retina. This is because the axial length of the eye is shorter than a normal (emmetropic) eye. It can give rise to problems seeing objects clearly for near, but in moderate amounts may also affect the distance vision. It is most commonly associated with convergent squints.
Latent Nystagmus	When one eye is covered an involuntary rhythmic shaking/ oscillation of the eyes occurs. Vision is better with both eyes open.
Manifest Nystagmus	An involuntary rhythmic shaking/ oscillation of the eyes, which can be seen with both eyes open. Vision is usually reduced to varying degrees. Vision is usually better both eyes open.
Microphthalmia	A condition that means the eyes started to form during pregnancy but for some reason stopped, leaving the infant with small eyes.
Myopia	This is a type of refractive error also known as short-sightedness. Rays of light entering the eye come to focus in front of the retina. This is because the axial length of the eye is longer than a normal (emmetropic) eye. It gives rise to problems seeing clearly in the distance.

Nystagmus	An involuntary rhythmic shaking or oscillation of the eyes. It can be manifest or latent see above. It can be congenital or acquired.
Null Point/ Zone	The point at which nystagmus/ shaking of the eyes is at a minimum and the vision at a maximum. This is usually achieved by turning the head.
Occlusion	This is a treatment for amblyopia (reduced vision). A patch is placed over the good eye in order to stimulate the vision in the lazy eye. NB: patching does not eliminate a squint or replace the need for glasses.
Pseudosquint/strabismus	This is the term used to describe the appearance of squint (in the absence of a manifest squint) in babies and young children. Most often caused by epicanthic folds, a broad bridge of the nose or facial symmetry.
Ptosis	This is a drooping of the upper eyelid which may be partial or complete (totally obscuring the pupil). It may be unilateral or bilateral.
Refractive Error	An imbalance in the optical system which interferes with the way light rays are focused within the eye. This includes be hypermetropia, myopia and astigmatism. It is said to be high when strong spectacles are required, these will usually have been worn from a young age i.e. preschool and primary school.
Refraction	o Subjective refraction requires a patient to co-operate and respond to questions posed in the assessment of refractive error; patients would report on how changes in lens power impact on their level of visual acuity. o Objective refraction is the assessment of refractive error without input from the patient. Objective refraction is principally undertaken using retinoscopy to determine refractive error independently of patient input. This test determines if glasses are required and the strength of lenses required to correct the refractive

	error. The test may reveal hypermetropia, myopia and/or astigmatism. To ensure the test is accurate drops are usually instilled which temporarily inhibit focusing and enlarge the pupils which also permits examination of the back of the eye. These drops are called 'cycloplegic' drops.
Retinoblastoma	Is a childhood cancerous tumour of one or both eyes. The common signs are a white "glow" or "glint" in the pupil of one or both eyes, white pupil in colour photographs or a squint.
Retinopathy of Prematurity (ROP)	It affects prematurely born babies. It consists of abnormal retinal vessels that grow mostly in an area where normal vessels have not yet grown in the retina.
Stereoacuity	The measure of binocular stereopsis. Recorded in second of arc.
Stereopsis	The ability to perceive the relative depth of objects ('3D' vision).
Strabismus /Squint	This is a manifest deviation in which one eye may turn inward, outward, upward or downwards

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Appendix 2 – Contact information for Trust Orthoptic Services

Belfast Health and Social Care Trust

Orthoptist	Contact number	Clinic Times	How to Refer
Dr P Anketell	028 9615 3957	Monday - Friday	Please place an order on EPIC for in trust. For primary care refer by CCG Or by paper send a letter to the Central Booking Office, Royal Victoria Hospital Belfast, BT12 6BA
Mrs G Lamont			
Miss C McAtamney			
Miss K Harpur			
Miss S Kirk			
Miss B Thompson			
Miss K Lavery			
Miss Á Gribbin			
Miss A Owens			

Location of Orthoptic Services in BHSCT

Royal Victoria Hospital
Orthoptic Services
Grosvenor Road
Belfast, BT12 6BA
Tel: (028) 9615 3957

Mater Hospital
45-51 Crumlin Road
Belfast, BT14 6AB

Knockbreda Health and Wellbeing Centre
110 Saintfield Road
Belfast
BT8 6GR

Beech Hall Health and Wellbeing Centre
21 Andersonstown Road ,
Belfast
BT11 9AF

Carlisle Wellbeing and Treatment Centre
40 Antrim Road
Belfast
BT15 2AX

The Arches
1 Westminster Avenue North
Belfast

BT4 1NS

Any enquiries regarding the service can be made to:
Pamela Anketell, Orthoptic Service Manager, Belfast Trust

Community Clinics	Orthoptist	How to refer
Lisburn Health Centre Level 4 Linenhall Street Lisburn BT28 1LU Ext 84805	Mrs Andrea Fox Mrs Rukhsana McCann Ms Beacom	Written referral Lisburn Health Centre Level 4 Linenhall Street Lisburn BT28 1LU Ext 84805
Stewartstown Road Health Centre 212 Stewartstown Rd Dunmurray Belfast BT17 0FB Ext 84805	Mrs Andrea Fox	Written referral Lisburn Health Centre Level 4 Linenhall Street Lisburn BT28 1LU Ext 84805
Bangor Health Centre Newtownards Road Bangor BT 20 4LD Ext 15307	Mrs Judith Bates	Written referral Orthoptic Clinic Bangor Health Centre Newtownards Road Bangor BT 20 4LD Ext 15307
Hospital Clinics		
Orthoptic Clinic First Floor Ulster Hospital Dundonald Belfast BT16 1RH Ext 80370	Miss Dolan Mrs Giles Mrs Boyd Ms McCracken	Written referral to Orthoptic Clinic First Floor Ulster Hospital Dundonald Belfast BT16 1RH
Downe Hospital 2 Struell Wells Road Downpatrick BT30 6RL Ext 88281	Mrs Susan Robinson Team Lead Orthoptist Downe and Lisburn Mrs Boyd	Written referral to Orthoptics Downe Hospital 2 Struell Wells Road Downpatrick BT30 6RL

Any enquiries regarding the service can be made to:
Lead Professional Orthoptist SET, Miss Patricia Dolan, Orthoptic Clinic. OPD, Ulster Hospital, Upper Newtownards Road, Dundonald
Tel: (028) 9048 4511 Ext 80370

Clinics	Contact Telephone no	How to Refer
Armagh Community Hospital	028 3756 2477	Directly to: Orthoptic Office Ground Floor Finance Building Lurgan Hospital 100 Sloan St Lurgan Craigavon BT63 8NX
Banbridge Polyclinic		
John Mitchel Place Newry		
Dungannon Health Centre		
Lurgan Health & Social Services Centre		
Portadown Health Centre		

For all clinic/patient enquiries, please contact the Orthoptic Office Tel 028 3756 2477

Any enquiries regarding the service can be made to:

Clare Stevenson,
Acting Deputy Head of Orthoptic Service,
Orthoptic Office
Ground Floor Finance Building
Lurgan Hospital
100 Sloan St
Lurgan
Craigavon BT63 8NX

e-mail:clare.stevenson@southerntrust.hscni.net

Altnagelvin Hospital Tel: (028) 7134 5171 ext 215154
Glenshane Road
Londonderry, BT47 6SB

Clinician	Contact number	Clinic Times	How to Refer
Patrick McCance	028 71611424	Monday - Friday	Directly
Lisa Wallace			
David Wright			
Lesley Davis			

Tyrone County Hospital Tel: (028) 8283 3100 ext. 232137
Hospital Road
Omagh, BT79 0AP

Clinician	Contact number	Clinic Times	How to Refer
Audrey McBride	028 8283 3176	Monday - Friday	Directly
Cathy Donnelly			
Annemarie Peace			

South West Acute Hospital
124 Irvinestown Road Tel: (028) 6638 2174
Enniskillen
Co Fermanagh, BT74 6DN

Clinician	Contact number	Clinic Times	How to Refer
Ann-Marie Peace	028 6638 2174	Monday - Friday	Directly
Cathy Donnelly			

Roe Valley Hospital
Irish Green Street Tel: (028) 7776 1120
Limavady, BT49 9EU

Clinician	Contact number	Clinic Times	How to Refer
Lesley Davis	028 71611424	Monday	Forward referral to Altnagelvin Hospital

Shantallow Health Centre
64 Racecourse Road Tel: (028) 7135 3344
Londonderry, BT48 8DS

Clinician	Contact number	Clinic Times	How to Refer
Patrick McCance	028 71611424	1st & 3rd Thursday pm	Forward referral to Altnagelvin Hospital

Strabane Health Centre
Upper Main Street Tel: (028) 7138 4100
Strabane, BT82 8AR

Clinician	Contact number	Clinic Times	How to Refer
Lisa Wallace	028 71611424	Wednesday	Forward referral to Altnagelvin Hospital
Patrick McCance		1st Friday	

Castlederg Health Clinic
33a Main Street
Castlederg, BT81 7AS

Tel: (028) 8167 1406

Clinician	Contact number	Clinic Times	How to Refer
Audrey McBride	028 8283 3176	1st, 3rd & 5th Wednesday	Forward referral to Tyrone County Hospital

Fintona Health Centre
33 Dromore Road
Omagh, BT78 2BB

Tel: (028) 8284 1203

Clinician	Contact number	Clinic Times	How to Refer
Audrey McBride	028 8283 3176	1st Monday	Forward referral to Tyrone County Hospital

Belleek Health Centre
Belleek Health Centre
Rathmore Clinic
Belleek, BT93 3FY

Tel: (028) 6865 8382

Clinician	Contact number	Clinic Times	How to Refer
Annmarie Peace	028 6638 2174	1st Friday	Forward referral to South West Acute Hospital

Irvinestown Health Centre
Church Street
Irvinestown, BT94 1EH

Tel: (028) 6862 1212

Clinician	Contact number	Clinic Times	How to Refer
Annmarie Peace	028 6638 2174	2nd Thursday	Forward referral to South West Acute Hospital

Lisnaskea Health Centre
Drumhaw
Lisnaskea, BT92 0JB

Tel: (028) 6772 1566

Clinician	Contact number	Clinic Times	How to Refer
Cathy Donnelly	028 6638 2174	1st & 3rd Thursday	Forward to South West Acute Hospital

Any enquiries relating to the service may be made to:
Mr Patrick McCance, Orthoptic Services Manager,

Orthoptic Department, Altnagelvin Hospital, Londonderry
Tel: 028 71611424

Clinics Available	Contact Telephone no	How to Refer
Antrim Area Hospital	028 25635335	**Directly to: Orthoptic Admin Office, 1st Floor Rear Spine, Braid Valley site, Cushendall Road, Ballymena. BT43 6HL**
Ballymena Health & Care Centre		
Causeway Hospital, Coleraine		
Cookstown Community Care Centre		
Mid Ulster Hospital, Magherafelt		
Moyle Hospital, Larne		
Whiteabbey Hospital		

The Admin office is staffed Mon-Fri and can assist with enquiries regarding waiting lists. Orthoptists are present 2 mornings per week and Admin staff can direct enquiries to the appropriate clinician. It is likely that an Orthoptist will need the patient notes to deal with clinical enquiries.

Any enquiries relating to the service may be made to:

Jennifer Patterson, Head of Service for Orthoptics & ICATS Ophthalmology
Pinewood Offices, 101 Fry's Road, Ballymena, BT43 7EN
Tel: 07788379095