ST.LAWRENCE-LEWIS BOCES
SPECIAL EDUCATION PROGRAM
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Vision Evaluation Referral Form

Name of Student: _____Date of Birth: _____

Home Address: _____

_____

Parent(s)/Guardian(s) Name(s): _____

_____

Grade: _____ Teacher: _____

School:_____ Home District:_____

DIAGNOSIS, ETIOLOGY & HISTORY

A. DIAGNOSIS of present eye condition: _____

B. ETIOLOGY or underlying cause: _____

C. Severe ocular infections, injuries, operations, if any, with age at time of occurrence: _____

_____

D. Date of last Vision Exam: _____

E. Name of Ophthalmologist/Vision Specialist(s): _____

Address/Phone: _____

VISUAL ACUITY:

DISTANCE VISION:

	W/O CORRECTION	W/ BEST CORRECTION
RIGHT EYE (OD)	_____	_____
LEFT EYE (OS)	_____	_____
BOTH EYES (OU)	_____	_____

NEAR VISION:

	W/O CORRECTION	W/ BEST CORRECTION
RIGHT EYE (OD)	_____	_____
LEFT EYE (OS)	_____	_____
BOTH EYES (OU)	_____	_____

* If it is not possible to obtain a visual acuity measure, what is your opinion of what this child sees?

NLP☐ LIGHT PERCEPTION ☐ HAND MOTION ☐ COUNT FINGERS ☐

WORSE THAN 20/200 ☐ 20/70-20/200 ☐

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FIELD OF VISION: Is there a limitation? YES ☐ NO ☐

If so, please describe including degrees of remaining visual field _____

_____

Is there impaired color perception? YES ☐ NO ☐ If so, what color(s)? _____

If low vision device/devices are prescribed, specify type(s) and recommended use:

_____

_____

PROGNOSIS AND RECOMMENDATIONS:

Is student's vision impairment considered to be:

stable ☐ deteriorating ☐ capable of improvement ☐ uncertain ☐

What **TREATMENT** is ongoing, if any? _____

_____

When is **RE-EXAMINATION** recommended? months ☐ yearly ☐ never ☐

GLASSES: not needed ☐ wear part of the time ☐ to be worn most of the time ☐

If so, specify _____

Prescription Strength: _____

LIGHTING requirements: average ☐ better than average ☐ less than average☐

Does the present condition necessitate limited use of vision? Choose an item.

Specify _____

_____

PHYSICAL ACTIVITY: ☐unrestricted ☐Restricted as follows: _____

_____

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To assist BOCES in fulfilling your request, please indicate the Reason for the Request:

☒To determine if student's vision has educational implications

☐To understand how student's vision is impacting educational setting

☐To determine compensatory and teaching strategies/classroom support

☐Questioning as to whether student requires vision service due to diagnosed visual impairment

☐Questioning as to whether student requires Orientation/Mobility services

☐OTHER _____

Any additional information that could be helpful understanding the concerns from staff/team:

_____

_____

_____

_____

A copy of a medical vision exam (within one year) MUST accompany this form AND the BOCES 'Request for Evaluation of Related Services' form when requesting a Vision Evaluation as this information is critical to assisting when making appropriate educational recommendations.