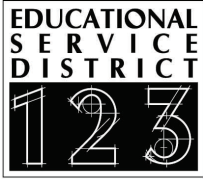

Special Services: Vision

Vision Referral

Student's Name ______________________ Referral Date ______________

Birth Date ______________ Age ______________ Grade ______________

District ______________ School ______________ Teacher ______________

Parent/Guardian ______________________ Home Phone ______________

Address ______________________ Work Phone ______________

Referral Source ____

Referred for the following:

- ❑ Functional vision evaluation
- ❑ Re-evaluation of functional vision
- ❑ Orientation and mobility evaluation
- ❑ Technology evaluation/consultation
- ❑ Other: ____

Concerns of Referral Source: ____

____

Concerns of Parent/Guardian: ____

____

Primary Physician:

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Telephone: ______________________

Diagnosis: ______________________

____

Eye Care Specialist:

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Telephone: ______________________

Diagnosis: ______________________

Acuity: ______________________

Services currently receiving (e.g. hearing, OT, PT, speech/language): ______________________

____

Signature of Referring Person ______________________ Referral Date ______________

Address ______________________ Phone ______________

Return Completed Form To: Special Services Department, Attn: Vision Services, Educational Service District 123, 3918 W Court St, Pasco WA 99301