Student's Name: ___________________________

Parent & Teacher Pre-Evaluation Form

Colorado Low Vision Evaluation Clinic

Attention Parents, Guardians, and Teachers:

IMPORTANT: ***This form should be completed by a TVI*** with the assistance and input of the student's parent or guardian through phone, virtual, or in-person meeting contact. It should ***not*** be sent home for parents or guardians to complete independently.

The following mentioned student is scheduled to receive a low vision evaluation sponsored by the Colorado Department of Education Exceptional Student Services Unit (CDE ESSU) and the Colorado School for the Deaf and the Blind (CSDB). ***Your thoroughness in completing this report is essential in the process of providing the most appropriate services for him or her.*** *Thank you.*

STUDENT NAME: ____

Has the student been identified as having a visual disability and is currently receiving special education services in a Colorado administrative unit?

☐ yes ☐ no

Does the student have an active Individualized Education Program (IEP)?

☐ yes ☐ no

If the answer to either or both of the above two questions is "NO", this learner is not eligible to be a candidate for the Colorado Low Vision Evaluation Clinic and this form should not be completed.

D.O.B. ___________/____________/____________ ☐ **Male** ☐ **Female**

Grade:________________________School:____

Administrative Unit: ____

School District: (☐ same as AU) ____

Clinic Site: ____

TVI: ____

O&M Instructor (☐ same as TVI): ____

Student's Name: ___________________________

This is a/an (*circle one*) ***Initial / Follow-Up*** Low Vision Evaluation for this student at the Colorado Low Vision Evaluation Clinic.

If this is a follow-up appointment, what was the date of the student's last low vision evaluation?

____

Please fill in all that apply: Student is currently living with: __________________________________

Other (list)

The low vision evaluation performed by the clinic team is a 90-minute process to increase access and improve the function of the student's visual world. This evaluation is funded by the CDE ESSU and CSDB. The purchase of low-vision devices is the responsibility of the parent/guardian. Low Vision devices range in price from $13 to $200 with most being less than $100. *Families and school districts will not receive any ordered devices until payment is received.* **The clinic does not accept credit cards** so purchases must be **cash or check** (checks should be made out to "CSDB").

Parent/Guardian: Will you be able to pay for devices at the time of evaluation? ☐ ☐

TVI: If "no," please discuss alternate funding sources. How will devices be funded?

____

Parent/Guardian: Do you consent to have photos of your child taken during the clinic to be included in the clinic report? ☐ yes ☐ no

Can any photos of your child be used on the CDE and/or CSDB website or educational or training materials that describe the activities of the Low Vision Evaluation Clinics?
☐ yes ☐ no

A Low Vision Evaluation Clinic report will be sent to the TVI, parent/guardian, and the student's eye health care provider. The parent/guardian signature below permits us to send a copy of that report to your administrative unit/education agency, the student's teacher of students with visual impairments, orientation and mobility specialist, and your primary eye care specialist(s). Please provide the **name** and **complete mailing address** of any additional individuals you wish to receive a copy of the report in the spaces provided below. This form can be signed on the day of the clinic.

____ ________________________

Parent/Guardian Signature Date

Student's Name: ___________________________

Please fill out each address **COMPLETELY**. Do not leave any blank spaces.

PRINT NEATLY AS THE FOLLOWING CONTACT INFO WILL BE USED TO EMAIL THE REPORT.

Guardian(s)' Name: ____

Address: _________________________________ City, State, Zip: ___________________________

Phone: ( ) __________________________________

Email Address (*report will emailed to this address*): _______________________________________

TVI Name: ______________________________ School Name: ______________________________

Street Address of TVI: _______________________ City, State, Zip: __________________________

Phone: ( ) _________________________________

Email Address (*report will emailed to this address):* ______________________________________

***Primary Eye Care Physician*:** ☐ Ophthalmologist ☐ Optometrist

Name: ____

Address: __________________________________ City, State, Zip: __________________________

Email Address (*report will emailed to this address*): ______________________________________

Phone: ( ) __________________________________

Additional individuals or agencies who should receive a report:

Name:____

Address: _________________________________ City, State, Zip:___________________________

Phone: ( ) ______________________________ FAX: ( ) _____________________________

Email Address (*report will emailed to this address*): _______________________________________

Additional individuals or agencies who should receive a report

Name: ____

Address: ____________________________________ City, State, Zip: _________________________

Phone: ( ) _______________________________ FAX: ( ) __________________________

Email Address (**report will emailed to this address**): ____

Student's Name: ___________________________

VISUAL HISTORY AND FUNCTIONING

1. Date of the student's last eye exam?
2. Diagnosis of visual impairment (name of eye condition)? ___________________________
3. Age of visual impairment onset? __________________
4. Does anyone in the student's family have similar visual problems? ____________________

   ____

5. History of treatment, or surgery related to the visual impairment: ______________________

   ____

6. Which eye seems to be the student's **better** eye? ☐ Right ☐ Left ☐ No Difference
7. Explain any recent changes in the student's visual functioning: _______________________

   ____

8. Please check the box of any device(s) the student uses **AT HOME.**

☐ Eye Glasses Are the glasses used for: ☐ prescription ☐ protection

Glasses are worm for: ☐ Distance ☐ Near ☐ Both

☐ Magnifying Glass How many magnifying glasses? (pocket, stand, etc.) ________________

i. Brand: __________________________ Magnification strength: ____________

☐ Stand ☐ Handheld ☐ Illuminated ☐ Non-illuminated

ii. Brand: __________________________ Magnification strength: ____________

☐ Stand ☐ Handheld ☐ Illuminated ☐ Non-illuminated

☐ Electronic book Please specify: (i.e., Kindle, Noble Nook, etc.) _____________________

☐ LapTop Computer Please specify: (i.e., touchscreen, mouse, etc.) ____________________

Please specify the screen size of computer, eBook, tablet, etc. ___________________________

☐ Tablet Computer Please specify: (i.e., iPad, Samsung, etc.) ________________________

☐ Monocular/binocular Brand: ________________ Magnification strength: ________________

☐ Desk-Top Electronic Video Magnifier (formerly called a closed-circuit television, or CCTV)

☐ Portable Video Magnifier ☐ Desk-top Computer ☐ Other: _________________________

Student's Name: ____________________________

9. Please check the box of any device(s) the student uses **AT SCHOOL.**

☐ Eye Glasses Are the glasses used for: ☐ prescription ☐ protection

Glasses are worm for: ☐ Distance ☐ Near ☐ Both

☐ Magnifying Glass How many magnifying glasses? (pocket, stand, etc.) ____________________

i. Brand: ____________________________ Magnification strength: ________________

☐ Stand ☐ Handheld

☐ Illuminated ☐ Non-illuminated

ii. Brand: ____________________________ Magnification strength: ________________

☐ Stand ☐ Handheld

☐ Illuminated ☐ Non-illuminated

☐ Electronic book Please specify: (i.e., Kindle, Noble Nook, etc.) __________________________

☐ LapTop Computer Please specify: (i.e., touchscreen, mouse, etc.) __________________

Please specify the screen size of computer, eBook, tablet, etc. ____________________________

☐ Tablet Computer Please specify: (i.e., iPad, Samsung, etc.) ________________________

☐ Monocular/binocular Brand: ____________________ Magnification strength: ________________

☐ Desk-Top Electronic Video Magnifier (formerly called a closed-circuit television, or CCTV)

☐ Portable Video Magnifier ☐ Desk-top Computer ☐ Other:____________________________

☐ Desk-Top Electronic Video Magnifier (formerly called a closed-circuit television, or CCTV)

☐ Portable Video Magnifier ☐ Desk-top Computer ☐ Other: ___________________________

10. Does your student use any devices or other accommodations when taking classroom or standardized tests? If so, please list: ____

____

11. What learning system is used for school (i.e., Canvas, Blackboard, etc.): ________________________

____

12. Please list any visual behaviors you have noticed that you are concerned about.

☐ Removes glasses ☐ Looks over/under glasses

☐ Holds print at a close distance (___________inches)

☐ Other: ____

13. Where does the student do his or her homework, leisure reading, or other visual tasks?

☐ Desk ☐ Table ☐ Floor ☐ Other: ____

Student's Name: ____________________________

14. At home, what type of lighting does the student use?

☐ Desk Lamp ☐ Floor Lamp ☐ Overhead ☐ Prefers Dim Light

☐ Incandescent ☐ Fluorescent ☐ Halogen ☐ Other: ______________________

15. Does the student see better or more comfortably on:

☐ Bright/sunny days? ☐ Overcast /cloudy days?

16. Is the student bothered by glare? ☐ No ☐ Yes

If yes, does the student regularly use something to reduce and prevent glare? ☐ No ☐ Yes If yes, does s/he make use of: (check all that apply)

☐ sunglasses (color of lens preferred:_________________________________)

☐ visor

☐ brimmed hat

MEDICAL HISTORY

17. Does the student have hearing loss? ☐ No ☐ Yes

If yes, please describe the level of hearing loss: ____

18. Does the student have any difficulties other than his or her visual impairment? ☐ No ☐ Yes

If yes, please explain: ____

____

19. List the **medications** the student is currently taking and any special medical treatments he or she has had or is receiving:

____

____

____

Student's Name: ___________________________

ORIENTATION AND MOBILITY

20. Is the student currently receiving orientation and mobility (O&M) instruction? ☐ Yes ☐ No

21. List any devices or aids the student uses for orientation and mobility:

☐ Adaptive mobility device (AMD) ☐ Long white cane

☐ Monocular telescope ☐ GPS: (type): ______________________________

☐ Other: ___________________________

22. Can the student travel alone? Around his/her neighborhood? School? Other? (Please explain)

____

____

____

____

LEARNING MEDIA PLAN

The written IEP for each child with a visual impairment, including blindness or deafblindness shall include a Learning Media Plan as developed by the IEP team based on comprehensive assessment of the student's learning and literacy modalities by a licensed teacher endorsed in the area of visual impairment. 4.03 (6)(b)(i). The following information may be copied directly from your student's most recent IEP.

Learning Medium:

☐ This student is a **Pre-Reader / Not Currently Reading** OR

Please indicate the selected learning and literacy mode(s) for this child/student to achieve literacy. Literacy modes include: (a) auditory mode, (b) Braille or tactual mode, (c) print enlargement or visual mode with optical enhancement, and/or (d) regular print or visual mode.

Current Learning and Literacy Mode(s): Primary: __________ Secondary: __________

(if appropriate): Co-Primary: _______ Co-Secondary: ________

Recommended Learning and Literacy Mode(s): Primary: __________ Secondary: ___________

If reading regular print, What size print is used: ____________

What viewing distance is used: ____________

Student's Name: ___________________________

Which of the following is the student using to access their regular print: (check all that apply)

☐ bifocals

☐ reading glasses

☐ magnifiers

☐ electronic magnification

☐ video magnifier (CCTV)

Comments: ____

____

____

____

If large print is recommended,

What type of font is used:_______________

What size font is used: _________________

What viewing distance is used: ___________

Which of the following is the student using in combination with their enlarged print (check all that apply):

☐ bifocals

☐ reading glasses

☐ magnifiers

☐ electronic magnification

☐ video magnifier (CCTV)

Comments: ____

____

____

Please list any additional comments that might help the low vision evaluation clinic team:

____

____

____

____

Student's Name: ___________________________

23. **PARENTS/GUARDIAN:** Aside from any near or distance devices that may be beneficial for your child, is there any specific information that you would like from this evaluation?

____
____
____
____

24. **TEACHERS**: Aside from any near or distance devices that may be beneficial for your student, is there any specific information that you would like from this evaluation?

____
____
____
____

Thank you for taking the time to fill out this information to help the LVE clinic team with the evaluation of the student. We look forward to seeing you and your student at the clinic. **This paperwork must be received by the low vision team at <u>a minimum of two weeks</u> before the child's appointment** in order for the LVE team to fully prepare for the appointment and to confirm the student's clinic appointment.

We cannot guarantee that a student will be accepted into the clinic if the paperwork is not complete or submitted at least two weeks before the clinic dates.