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 assistance and input of the student's parent or guardian through phone or meeting contact. It should ***not*** be sent home for parents or guardians to fill out 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: Both Parents / Mother / Father / Guardian / **Other** (list) _____

The low vision evaluation performed by the clinic team is a 90-minute process to increase access and improve 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 time of evaluation?

☐ yes ☐ no

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

_____

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** for any additional individuals you wish to receive a copy of the report in the spaces provided below. This form can be signed the day of the clinic.

_____ _____ / _____ / _____

Parent/Guardian Signature Date

Student's: Name_____

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

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

Guardian(s)' Name: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

TVI Name: _____

School Name and Street Address of TVI: _____

City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

Primary Eye Care Physician: ☐ Ophthalmologist ☐ Optometrist

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

Additional individual or agency who should receive a report:

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

Additional individual or agency who should receive a report

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ FAX: ( ) _____

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**

☐ Reading Glasses ☐ Magnifying Glass ☐ Electronic book (i.e. Kindle)

☐ Desk-top Computer ☐ Lap Top Computer ☐ Tablet Computer (i.e. iPad)

☐ Desk-Top Electronic Video Magnifier (formerly called at a closed-circuit television)

☐ Portable Video Magnifier ☐ Monocular / binocular ☐ Other:_____

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

☐ Reading Glasses ☐ Magnifying Glass ☐ Electronic Book (i.e. Kindle)

☐ Desk-top Computer ☐ Lap Top Computer ☐ Tablet Computer (i.e. iPad)

☐ Desk-Top Electronic Video Magnifier (formerly called at a closed-circuit television)

☐ Portable Video Magnifier ☐ Monocular / binocular ☐ Other:_____

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

_____

Student's: Name_____

10. 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: _____

_____

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

☐ Desk ☐ Table ☐ Floor ☐ Other: _____

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

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

☐ Incandescent ☐ Fluorescent ☐ Haloge ☐ Other: _____

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

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

14. 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)

- O sunglasses (color of lens preferred: _____)
- O visor
- O brimmed hat

Student's: Name_____

Medical History

15. Does the student have a hearing loss?

☐ No ☐ Yes If yes, please describe the level of hearing loss: _____

_____

16. Does the student have any difficulties other than his or her visual impairment?

☐ No ☐ Yes If yes, please explain:

_____

_____

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

_____

_____

Orientation and Mobility

18. Is the student currently receiving orientation and mobility (O&M) instruction?

☐ Yes ☐ No

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

☐ Adaptive mobility device (AMD)
☐ Long white cane
☐ Monocular telescope
☐ GPS: (type): _____
☐ Other: _____

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

_____

_____

_____

_____

Student's: Name_____

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: _____

Is the student using bifocals, reading glasses, magnifiers, electronic magnification, or a video magnifier (CCTV) to access their regular print? Explain: _____

_____

If large print is recommended, What type font is used: _____

What size font is used: _____

What viewing distance is used: _____

Is the student using bifocals, reading glasses, magnifiers, electronic magnification, or a video magnifier (CCTV) in combination with their enlarged print?_____

_____

Student's: Name_____

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

_____

_____

_____

_____

21. **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?

_____

_____

_____

22. **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.