VISION SERVICES REQUEST CHECKLIST

(Please return with referral packet)

☐ **Initial referral for vision impairment assessment**

- ☐ 1. Eye Report
- ☐ 2. Vision Behaviors checklist
- ☐ 3. Orientation and Mobility checklists
  (1 parent and 1 school, or 1 completed jointly)
- ☐ 4. ESU #7 referral forms

☐ **Re-evaluation referrals**

- ☐ 1. Current eye report (within six months)
- ☐ 2. Referral form
- ☐ 3. Orientation and mobility checklist
  (If requesting O & M as new service)

☐ **Related Service/Consultation**

- ☐ 1. Current eye report (within six months)
- ☐ 2. MDT report/verification
- ☐ 3. List of concerns
- ☐ 4. ESU #7 referral form

☐ **Transfer student**

- ☐ 1. Current eye report
- ☐ 2. MDT report/verification
- ☐ 3. Current IEP
- ☐ 4. ESU #7 referral
- ☐ 5. O & M checklists from both parent and school
  (If O & M is not addressed in IEP)

VISION BEHAVIORS CHECKLIST

Name: _____Age: ___Date: _____Wears Glasses? _____

Respondent's Name: _____ Phone#:_____

Please check any area below that pertains. Feel free to write additional notes on back.

- ☐ One eye turns in or out
- ☐ Closes or covers one eye
- ☐ Tilts or turns head when reading
- ☐ Frequent blinking or tearing in eyes
- ☐ Squints one or both eyes
- ☐ Complains of frequent headaches

- ☐ Places head close to book or desk when reading or writing
- ☐ Holds things close to see it
- ☐ Needs to sit close to television to see it
- ☐ Difficulty following the flight of a ball
- ☐ Difficulty copying from board or book
- ☐ Short attention span or daydreaming

- ☐ Difficulty with step-downs
- ☐ Difficulty judging where things are in space
- ☐ Bumps into things and people
- ☐ Does not read to end of line
- ☐ Does not start at beginning of line or page

- ☐ Needs more light than expected to read
- ☐ Difficulty reading words superimposed over pictures

- ☐ Difficulty reading light color markers on white board
- ☐ Pause when coming indoors on sunny days
- ☐ Difficulty moving around in decreased lighting

- ☐ Head movement instead of eye movement
- ☐ Poor eye-hand coordination
- ☐ Loses place frequently while reading
- ☐ Rereads or skips lines unknowingly while reading
- ☐ Omission of small words when reading orally
- ☐ Needs to use finger as guide in reading
- ☐ Difficulty remembering, identifying reproducing basic geometric forms

- ☐ Poor reading fluency
- ☐ Shows fatigue or avoids or close work
- ☐ Difficulty completing written activities within allotted time
- ☐ Difficulty identifying omissions in written work
- ☐ Math errors due to misalignment of numbers

ORIENTATION AND MOBILTIY CHECKLIST

This checklist is used to determine student need for more comprehensive orientation and mobility evaluation. Many of the items presented are age/experience related and may not apply to every child.

According to "The Safety Book for Active Kids" by Linda Schwartz, most children are unable to accurately judge whether a street is safe to cross until at least age 8. Before then, they have trouble deciding…

*which direction sounds are coming from

*do not realize that cars cannot stop immediately

*cannot judge how fast traffic is moving

*often believe that if they see a driver, the driver can also see them

Young children also have much smaller fields of vision than adults. Children as well as adults who have difficulty with visual acuity, visual functioning, and/or visual perception may be unable to make the necessary judgments for safe street crossing without specialized training from an orientation and mobility specialist in alternative techniques. Small communities where streets are seldom traveled by vehicles may actually be more, rather than less dangerous, for children to cross. Since, the infrequency of vehicles fosters a sense of safety, it may cause carelessness on the part of the pedestrian, in which, and the drivers may not be able to react quickly enough to the actions of small children.

PART III
ORIENTATION AND MOBILITY SCREENING TOOL

Student's Name: _____ Date of Birth: _____ Date of Screening: _____

School: _____ Completed by: _____ Title: _____

Please check the appropriate response to the following statements and explain any NA (not applicable) statements:

YES	NO	NA/EXPLAIN	SCREENING STATEMENT	POINTS
			Travels independently without a sighted guide	
			Avoids stationary objects before contact	
			Avoids moving obstructions before contact	
			Locates unoccupied seat	
			Easily learns to travel in new settings	
			Travels without difficulty in presence of bright light (or glue)	
			Travels normally in dimished illumination	
			Efficiently & accurately detects drop-offs, steps, curbs (and ramps)	
			Efficiently locate landmarks	
			Independently walks in home neighborhood	
			Safely crosses streets	

Total Score (Score below 16 indicates a probable need for an Orientation and Mobility Evaluation)

Check the appropriate statements:

☐ Based on the findings of the above screening and discussion of the IEP team, an Orientation and Mobility Evaluation is recommended. The request for such an evaluation will be made of a Certified Orientation and Mobility Specialist. A copy of this screening will be sent with that request.

☐ Based on the findings of the above screening and discussion of the IEP team, an Orientation and Mobility Evaluation is NOT recommended at this time.

☐ Without consideration of the student's performance, the parent is requesting an Orientation and Mobility Evaluation.

Vision Examination Report

ESU 7

Patient's Name: _____

Date of Birth:_____ Date of Exam:_____

Ocular History- (Previous eye diseases, injuries, surgeries, etc.)

Age of onset:_____ History:_____

_____

Acuity- Please indicate the patient's visual acuities and or peripheral fields as listed below. (CNSM is not acceptable for the Federal Quota Registration of students with visual impairment)

	OD	**OS**
Visual Acuity- Distance, Corrected		
Visual Acuity –Distance, Uncorrected		
Visual Acuity- Near, Corrected		
Visual Acuity- Near, Uncorrected		

OR

Counts Fingers		
Hand Movements		
Object Perception		
Light Perception		
Totally Blind		
Unable to Determine		

Visual Field - Attach diagram if available

	Yes	**No**
No apparent field restriction		
Visual field restricted to 20 or less		
Visual field restricted to 60 or less		
Central field loss of any degree, in both eyes		
Hemianopsia		
Scotomas		

Notes_____

_____

(Over)

Muscle Function

☐ Normal ☐ Abnormal- Describe _____

Diagnosis

_____

_____

Color Vision: ☐ Normal ☐ Abnormal

Photophobia: ☐ Yes ☐ No

Eye condition is: ☐ Progressive ☐ Stable ☐ Immutable ☐ Uncertain

Does the patient function at the Definition of Blindness (FDB) due to brain injury or dysfunction? ☐ Yes ☐ No

Recommendations: ☐ Glasses ☐ Surgery ☐ Patch L/R

☐ Other _____

Precautions/ Suggestions: _____

_____

Print name of licensed Ophthalmologist or Optometrist: _____

Address:_____ City:_____ State:____ Zip:_____

Signature of licensed Ophthalmologist or Optometrist: _____

Telephone Number: _____

Reset Form

Return Completed form to: Educational Service Unit 7
Attn: Teacher of the Visually Impaired
Special Education Department
2657 44th Ave
Columbus, NE 68601