Referral for Special Education Services
Visual Impaired

STUDENT INFORMATION Today's Date: ___________

| | | | |
|---|---|---|---|
| Student Last Name | Student First Name | Birthdate | Age |

| | | |
|---|---|---|
| Student Address | City/Zip | Grade/School |

| | | |
|---|---|---|
| Resident District | Attending District | Teacher/Case-Manager Name (contact info) |

| | | | |
|---|---|---|---|
| Parent/Guardian Name(s) | Home Phone | Cell Phone | Email |

REASON FOR REFERRAL (attach additional information if necessary)

Does the student have a current IEP? YES / NO Or current 504? YES / NO

SERVICES BEING REQUESTED – please describe the type of services being requested below.

| |
|---|
| Functional Vision Assessment: |
| Consultation: |
| Orientation and Mobility: |
| Other vision related services: |

Please attach most recent ophthalmological report

REFERRED BY:

| Name/Title: | Phone/Email: |
|---|---|

Received (WISD): Name ________________________________________ Date ________________

Mail completed form and eye report to the below address or FAX to 734.913.5957 attn: VI Department