REFERRAL FORM FOR SERVICES FOR THE VISUALLY IMPAIRED

MANITOBA EDUCATION
Program and Student Services Branch
204 – 1181 Portage Avenue
Winnipeg, MB R3G 0T3

Date: _____

BACKGROUND INFORMATION

Student: _____ Grade: _____ Date of Birth: _____ (month/day/year)

Parent's Name: _____

Address: _____ Phone Number: _____ (Postal Code)

School: _____ Phone Number: _____

Address: _____ (Postal Code)

Classroom Teacher: _____ Principal: _____

School Division: _____ No.: _____ Phone Number: _____

Address: _____ (Postal Code)

Special Education Coordinator: _____

Other Professionals Involved: _____

Person Making the Referral: _____ Resource Teacher: _____

Eye Care Practitioner's Name: _____

Address: _____

Date of Examination: _____

Other Pertinent Medical information/medication: _____

VISUAL FUNCTIONING

A. Describe the visual difficulties the student exhibits:

_____

_____

B. **Visual Aids:**

1) Check if student uses: Glasses: _____ (tinted lens or glasses) Magnifiers: _____

Comments: _____

_____

C. Visual Skills:

1) Near tasks (desk tasks: cutting, drawing, reading, pictures, symbols, concrete objects, etc.).

2) Distance tasks (blackboard, mobility, playground, body language, gym, etc.).

D. Environmental Factors:

1) Preferred light source (natural/artificial).

?) Abnormal reaction to light (gazing/flicking).

Architectural barriers (curbs, stairs, doorways, etc.).

I am requesting that consultant services be provided to my visually impaired child. I understand that this may include a functional vision assessment.

Signature of Parent

NOTE: In order to act on this referral, an eye report based on an eye examination performed **within the last 12 months** is required. If the parent will sign the eye report form and indicate the name and address of the student's eye doctor, the Department will be willing to contact the eye doctor directly.

PLEASE SEND COMPLETED FORM TO:

Freya Martinot
Manager
Manitoba Education
Program and Student Services Branch
204 – 1181 Portage Avenue
Winnipeg, MB R3G 0T3