South Bend Community School Corporation
Special Education Services
215 S. Martin Luther King Jr. Blvd., South Bend, IN 46601
Ph: 574.393.6119 Fax: 574.283.810

Medical Referral for Students with Visual Impairments

Student Name: _____ SBCSC ID#: _____ STN#: _____
School/Preschool: _____ DOB: _____ Date: _____

To the Physician:

The South Bend Community School Corporation provides special education and related services to students who qualify for special education under federal and state law.

A medical referral has been initialted for the above-named student. Establishment of elitigibility for services under one of these disabilities is made by the case conference committee. The services which are needed are identified in an Individual Educational Plan (IEP).

We are required to have the written diagnostic statement on file. Please complete the information as indicated and return the form to the address above. If you have any questions, please contact the Special Education Department at 574.283.8130.

It is very important to complete the information below to assist in the educational planning for the above-named student.

Medical Diagnosis: _____

Comments/Concerns: _____

_____

Educational Implications: _____

_____

Physician Name: _____
(Please Print) (Signature)

Physician's Address: _____

_____

Phone: _____ Date: _____

CONFIDENTIAL **Eye Report for Children with Visual Problems**

Name of Pupil: _____ Sex: _____
(Type or Print) (First) (Middle) (Last)

Address: _____ DOB: _____
(No. and Street) (City or Town) (State) (Zip)

Grade: _____ School: _____ Address: _____

I. History

A. Probable age of onset of vision impairment: Right eye (O.D.) _____ Left eye (O.S.) _____

B. Severe ocular infections, injuries, operations, if any, with age at time of occurrence: _____

_____

C. Has pupil's ocular condition occurred in any blood relatives? _____ If so, what relationship? _____

II. Measurements (See next page for preferred notation for recording visual acuity table of approximate equivalents

A. Visual acuity

	Distant Vision			Near Vision			Prescription		
	Without Correction	With best correction	With low vision aid	Without correction	With best correction	With low vision aid	Sph.	Cyl.	Axis
Right eye (O.D.)									
Left eye (O.S.)									
Both eyes (O.U.)									

Date: _____

B. If glasses are to be worn, were safety lenses prescribed in: Plastic? _____ Tempered glass? _____

C. If low vision aid is prescribed, specify type and recommendations for use: _____

D. Field of Vision: Is there a limitation? _____ If yes, record results of test on next page.

E. What is the widest diameter (in degrees) of remaining visual field? O.D. _____ O.S. _____

F. Is there impaired color perception? _____ If yes, for what colors? _____

III. Cause of Blindness or Vision Impairment

A. Present ocular condition(s) responsible for vision impairment. (If more than one, specify all but underline the one which probably causes severe vision impairment.
O.D._____
O.S._____

B. Preceding ocular condition, if any, which led to present condition, or the underlined condition specified in A.
O.D._____
O.S._____

C. Etiology (underlying cause) of ocular condition primarily responsible for vision impairment (e.g. specific disease, injury, poisoning, heredity or other prenatal influence)
O.D._____
O.S._____

D. If etiology is injury or poisoning, indicate circumstances and kind of poison or object involved.
O.D._____
O.S._____

VI. Prognosis and Recommendations

A. Is pupil's vision impairment considered to be: Stable _____ Deteriorating _____ Capable of Improvement _____ Uncertain _____

B. What treatment is recommended, if any? _____

C. When is reexamination recommended? _____

D. Glasses: Not needed _____ To be worn constantly _____ For close work only _____ Other: _____

Specify: _____

E. Lighting Requirements: Average _____ Better than average _____ Less than average _____

F. Use of eyes: Unlimited _____ Limited, as follows: _____

Physical Activity: Unrestricted _____ Restricted, as follows: _____

To be forwarded by Examiner to:

Signature of Examiner: _____ Degree: _____ Date of Exam: _____

Address: _____

If clinic care: Number: _____ Name of Clinic: _____

Preferred Vision Acuity Notations

Distant Vision. Use Snellen notation with test distance of 20 feet. (Examples: 20/100, 20/60). For acuities less than 20/200 record distance of which 200 foot letter can be recognized as numerator of fraction and 200 as denominator. (Examples: 10/200, 3/200). If the 200 foot letter is not recognized as 1 foot, record abbreviation for best distant vision as follows:

HM	Hand Movements (Specify inches or feet)
PLL	Perceives And Localizes Light in one or more quadrants
LP	Perceives But Does not Localize Light
NoLP	No Light Perception

Near Vision. Use standard A.M.A. notation and specify best distance at which pupil can read. (Example: 14/70 at 5 in.)

Table of Approximate Equivalent Visual Acuity Notations

These notations serve only as an indication of the approximate relationship between recording of distant and near vision and point type sizes. The teacher will find in practice that the pupil's reading performance may vary considerably from the equivalents shown.

	Near				% Central Visual	
Distant Snellen	**A.M.A.**	**Jeager**	**Metric**	**Efficiency for Near**	**Point**	**Usual Types of Text Size**
20/20 (ft)	14/14 (in)	1	0.37 (M)	100	3	Mail Order Catalog
20/30	14/21	2	0.50	95	5	Want Ads
20/40	14/28	4	0.75	90	6	Telephone Directory
20/50	14/35	6	0.87	50	8	Newspaper Text
20/60	14/42	8	1.00	40	9	Adult Text Books
20/80	14/56	10	1.50	20	12	Children's Books 9-12 yrs
20/100	14/70	11	1.75	15	14	Children's Books 8-9 yrs.
20/120	14/84	12	2.00	10	18	Large type text
20/200	14/140	17	3.50	2	24	Large type text
12.5/200	14/224	19	6.00	1.5		
8/200	14/336	20	1			
5/200	14/560					
3/200	14/900					

Field of Vision. Record results on chart below.

Type of Test used: _____ Illumination in ft. candles: _____