Please return this form to:
School:
Attn:
Street Address:
City, NE Zip:
FAX #:

Request for Vision Services

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

Parent/Guardian: _____ **Address:** _____

Phone: ( ) _____ _____

Your patient has been referred for:

☐ A Functional Visual Assessment in the educational environment

☐ An evaluation to determine eligibility for Rule 51 Verification of Visual Impairment

☐ A three year re-evaluation to determine eligibility for Rule 51 Verification of Visual Impairment

Date of Last Eye Exam: _____

Visual diagnosis including etiology: _____

_____

Eye condition is considered to be: ☐ Progressive ☐ Stable ☐ Immutable ☐ Uncertain

Glasses Prescribed? ☐ yes ☐ no

	O.D.	O.S.	O.U.		O.D.	O.S.	O.U.
Visual Acuity (best corrected, for **distance**) *or*	☐	☐	☐	Light Perception	☐	☐	☐
Counts Fingers	☐	☐	☐	Object Perception	☐	☐	☐
Hand Movements	☐	☐	☐	Totally Blind	☐	☐	☐
Unable to Determine	☐	☐	☐	Visual Field Restriction	☐	☐	☐

Does the patient function at the definition of blindness (FDB) due to visual performance being reduced by brain injury **or** dysfunction so that **visual acuity is not possible to determine using the Snellen Chart** and is it the determination of the eye care provider that this student meets the definition of blindness for **educational purposes?** ☐ **yes** ☐ **no**

Physician's typed or printed name: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The signature of the Parent/Guardian authorizes release of medical records and/or information to Name of Your School.