Region 14 - Hopewell Center
Consultation/Evaluation Referral Packet
For Children 3 to 22 Years Old

Please use this packet to request the following Hopewell service:

Educational Vision Evaluation

Please:

1. **Provide the child's name and social security number below,**
2. **Sign below, and**
3. **Send this page along with all information listed for the Audiological Evaluation you are requesting.**
4. **Send to Region 14 - Hopewell Center attention Mary Hiler.**

Thank You!

I am requesting Region 14 - Hopewell Center provide the service(s) indicated below for;

_____ _____
Child's Name Child's Social Security Number

- **Copy** of Referral for Evaluation (Form PR-04) if this is an initial evaluation **or** a re-evaluation
- Permission to Consult – **Enclosed**
- Eye Report for Children with Visual Problems if vision is a referral concern--**Enclosed**

Please indicate if student is Preschool or School Age, type of referral & due date:

	_____ ***Preschool***	_____ ***School Age***
o	**Transition Meeting**	**due date** _____
o	**Initial Evaluation**	**due date** _____
o	**Re-evaluation**	**due date** _____

Has student been identified with a disability? _____ **Yes** _____ **No**
Is student on an IEP? _____ **Yes** _____ **No**
Is student on a 504 ? _____ **Yes** _____ **No**

_____ _____ _____
District Contact Person Signature District Date

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

Name: _____ ID Number: _____

Street: _____ Gender: _____ Grade: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

BUILDING OF CURRENT ATTENDANCE

_____

Teacher(S):

_____

Student's Native Language (if not English)

_____

PARENT/GUARDIAN INFORMATION

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Parent's Native Language (if not English)

_____

Reason for Referral:

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

Provide data from previous interventions, including interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: _____
Years at present school building: _____
List schools/early childhood programs and dates:

ATTENDANCE:

_____Regular _____Irregular

Is this student age-appropriate for grade level? _____Yes _____No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with _____Vision _____Hearing
Does the student _____Wear Glasses _____Use Hearing aid(s)

PR-04 REFERRAL FOR EVALUATION

Does the student take medication _____Yes _____No

Does the student have any health/developmental/physical problems of which you are aware? _____Yes _____No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school.

For Preschool Children Only (please check the area(s) of concern):

_____ Eating
_____ Receptive Communication
_____ Cognitive
_____ Vision
_____ Other
_____ Dressing
_____ Expressive Communication
_____ Fine Motor
_____ Social/Emotional Behavior
_____ Toileting
_____ Hearing
_____ Play
_____ Attention
_____ Gross Motor

Describe any other pertinent information not previously described:

SIGNATURES

Signature of Person Initiating the Referral

Position or Relationship to Student

Date

Signature of Person Receiving the Referral

Title

Date Received

Date District Suspects a Disability

Permission to Consult

_____, hereby give my permission for
Parent/Legal Guardian/Surrogate

the Autism and Low Incidence Consultant from Southern Ohio Educational Service Center to

respond to a request for assistance for _____.
Name of Child

I am giving my permission for the following assessments (***please check all that apply***):

- ☐ Review of relevant records (releases of information will be included)
- ☐ Interviews with caregiver, myself, teacher
- ☐ Observation(s) of my child
- ☐ Assessment (e.g., curriculum-based, screening, and other appropriate measures to determine interventions)
- ☐ Other (please specify): _____

_____
Name of Parent/Legal Guardian/Surrogate

_____
Signature

_____
Date

Confidential

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS
MUST BE COMPLETED BY AN OPTOMETRIST OR OPTHAMALOGIST

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS

Date of Exam: _____/_____/_____

Name of Child _____ Date of Birth _____/_____/_____
(First) (Middle) (Last)

Address: _____
(Number and Street)

_____
(City or Town) (County) (State) (Zip)

Name of School: _____ Grade:_____

Address: _____
(Number and Street)

_____
(City or Town) (County) (State) (Zip)

I. History

A. Primary cause of visual impairment: _____
B. List any systemic disease(s) contributing to the ocular condition: _____
_____
C. Surgeries (i.e., contract, strabismic, other):_____
D. Medications: _____
(Please list all ocular and systemic medication)
E. Age of onset of visual impairment: _____

II. Refractive Correction

A. What is the child currently wearing or using? _____
_____
B. Current prescription: OD _____ OS _____

	Distance Visual Acuity Without Glasses	Distance Visual Acuity With Current Glasses	Near Visual Acuity Without Glasses	Near Visual Acuity With Glasses
Right Eye (OD)				
Left Eye (OS)				
Both Eyes (OU)				

C. Are new glasses recommended? _____Yes _____No
D. If yes, what is the child's best refraction? _____
E. Is low vision aid examination recommended? _____Yes _____No

	Sphere	Cylinder	Axis	Corrected Near Visual Acuity	Corrected Distance Visual Acuity
Right Eye (OD)					
Left Eye (OS)					

F. Is visual field normal? _____Yes _____No
If no, please attache or describe: _____

G. Is there normal color perception? _____Yes _____No
If no, what color _____
Please indicate test used _____

H. Is there evidence of light sensitivity? _____Yes _____No

Prognosis and Recommendations

A. Recommendation:

_____ Low vision examination _____Glasses

_____ Optical aids _____ Other: _____

Comments: _____

B. Preferred lighting: _____

C. Special tinted lenses/filters recommended? _____ Yes _____No

D. Specify need for physical restrictions: _____

E. Reading Model (s):

_____ Large Print _____ CCTV _____ Standard Print

_____ Braille _____ Tape

F. Prognosis: _____ Stable _____Deteriorating _____ Capable of Improvement

Comments:_____

Wish to see child again? _____Yes _____No If yes, when?_____

Doctor's Name (Signature) _____

Doctor's Name (Printed) _____

Address:_____

_____

Return to (School District): _____

Address:_____

_____