NMSBVI Access to Learning ~ Low Vision Clinic

TEACHER OF STUDENTS WITH VISUAL IMPAIRMENTS
LOW VISION PRE-EXAMINATION INFORMATION

Teacher of Students with Visual Impairment Contact Information:

Name):

Mailing Address:

Phone: **Cell:** **Email:**

Today's Date:

Student: DOB Sex: ☐ M ☐ F

Parent(s)'s Name:

Parent Daytime Phone: Home: Cell:

Student Information:
School Attending: District:

Student's grade placement:

- Student's educational placement: ☐ general education ☐ special education ☐ other (specify)
- Does the student presently wear glasses? ☐ Yes ☐ No

If so, are they:

☐ Worn for near work
☐ Worn for distance viewing
☐ Worn regularly
☐ Other

- What is the student's **primary** learning medium?
  ☐ Braille ☐ Regular print ☐ Large print ☐ Auditory
- What visual working distance is used for near tasks (reading, writing, viewing pictures, viewing smaller objects)?
- What is the best way to test the child's vision?

☐ Naming letters
☐ Naming shapes
☐ Matching shapes
☐ Other (specify)_____

- Does the student use any optical devices? ☐ Yes ☐ No
  If yes, please list:

- Does the student use any assistive technology? ☐ Yes ☐ No
  If yes, please list:

- Does the student have other medical conditions or impairments?
  Describe:

- Has student had O&M evaluation? ☐ Yes ☐ No If yes, date?
  (Attach a copy of the evaluation.)

- Does the student currently receive O&M services? ☐ Yes ☐ No

Describe any difficulties you see which you would like addressed as well as your goals/expectations for this evaluation and any additional information you feel is relevant to this evaluation:

To submit form electronically: save this file to your computer; fill in fields, save final file, and email final file as an attachment to margarethidalgo@nmsbvi.k12.nm.us

OR, to submit form via mail or fax:
NMSBVI-ECP, ATTN: Low Vision Clinic, 801 Stephen Moody Street SE, Albuquerque, NM 87123
Fax to 505-271-3073. Or Call: 575-415-6044