EDUCATIONAL SERVICE CENTER
of Northeast Ohio

REFERRAL TO DETERMINE ELIGIBILITY FOR VISUAL IMPAIRMENT SERVICES

School_____ Grade_____ District of Residence_____

School District of Service _____

Student Name_____DOB_____Age_____Sex_____

Home

Address_____City_____Zip_____Phone_____

Father's Name_____ Mother's Name_____

Name & title of person completing referral_____

Phone number of person completing referral _____

NOTE: This Evaluation will not be completed without a current eye report.

Student eligibility will be determined by an evaluation conducted by a teacher of the visually impaired. Following this initial assessment, further services such as evaluations for functional low vision and/or orientation and mobility will be recommended.

1. Is the student already on an IEP? If applicable, please attach the most current IEP and MFE.

2. If the child is not on a current IEP, what do you see as this student's strengths and weaknesses? (i.e., academic, language, social, motor, adaptive)

EACH REFERRAL MUST BE SIGNED

Name_____Date_____
Building Principal

Name_____Date_____
Director of Special Education/Pupil Services

RETURN TO: Visual Impairment Program, Educational Service Center of Northeast Ohio
Essex Place, 6393 Oak Tree Blvd. South, Independence, OH 44131 – Attn: Dana Lambacher
Email: Dana.lambacher@escneo.org

DO NOT SUBMIT WITHOUT A CURRENT EYE REPORT