BCIU # 22 REFERRAL FOR ORIENTATION & MOBILITY EVALUATION
TEACHER OR CASE MANAGER TO COMPLETE

Student Name_____ Date of Birth _____

School Nurse_____ Phone _____

Is the student already receiving vision support services? ☐ YES ☐ NO

If no, a physician's eye report dated within the last year MUST accompany this referral.

Eye Specialist _____ Phone _____

Street Address _____

City, State, ZIP _____

Reason for the referral:

Services the child is currently receiving: (Type & frequency)

SL: _____

OT: _____

PT: _____

Other: _____

A PTE is required for this evaluation. Please have the parent sign it only after you have received the completed eye report from the physician.

BCIU #22 PARENT NOTIFICATON AND PERMISSION FOR ORIENTATION AND MOBILITY EVALUATION
TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME_____

DATE OF BIRTH_____

Date: _____

Dear _____,

This letter is to inform you that your child is being referred to the Bucks County Intermediate Unit for an Orientation and Mobility evaluation. This process will determine if your child needs Mobility Support or recommendations within the educational setting.

Due to the HIPAA laws, we require your permission to receive information on your child's eye condition. Eye doctors are no longer permitted to release information without written permission from you, the parent/guardian.

Please sign and return this letter to the school nurse. At that time the Orientation and Mobility referral process will begin.

Thank you for your attention to this matter.

Sincerely,

_____

___ I give permission for an Orientation and Mobility referral to be initiated for my child.

___ I do not give permission for an Orientation and Mobility referral to be initiated for my child.

_____ _____
Parent Signature Date

SCHOOL NURSE: Please attach this signed permission to the eye report form that you will send to the eye doctor.

BCIU#22 REQUEST FOR EYE REPORT
TO BE COMPLETED BY SCHOOL NURSE

Date: _____

School: _____

Address: _____

_____

Attention: _____
(School Nurse)

Re: _____ DOB: _____
(Student Name)

This is a request for an eye report on the above named student, who is a patient of yours. This child is being referred to the Bucks County Intermediate Unit's Vision Support Program, and this information is necessary for the referral process.

Enclosed is a copy of the Bucks County Intermediate Unit's eye report form for your convenience. It would be most helpful if you would fill in the form as completely as possible and return it to my attention as soon as possible. Thank you for your cooperation in this matter.

Sincerely,

_____

(School Nurse)

BCIU #22 STUDENT EYE REPORT

TO BE COMPLETED BY STUDENT'S PHYSICIAN

Student Name: _____Date of Birth_____

Visual Examination (*Please fill in completely.*)

A. Diagnosis:_____

B. Onset: _____

C. Visual Acuity:

	Distance Vision			Near Vision		
	Without	with best	with low	without	with best	with low
Rt. Eye OD	_____	_____	_____	_____	_____	_____
Lf. Eye OS	_____	_____	_____	_____	_____	_____
Both Eyes OU	_____	_____	_____	_____	_____	_____

D. Tests (Charts) used: _____

E. Field of Vision 1. Peripheral OD_____ OS_____

2. Central OD_____ OS_____

F. Color Blindness (Description):

G. Are glasses to be worn? ☐ Yes ☐ No Tinted? ☐ Yes ☐ No

Prognosis & Recommendations

A. Impairment is (check): Stable ☐ Deteriorating ☐

Capable of improvement ☐ Uncertain ☐

B. What treatment, if any is recommended?

C. When is re-examination advised?

D. Glasses: ☐ Not Necessary ☐ Constant wear ☐ For close work

E. Physical activity: ☐ Unrestricted ☐ Restricted as follows:

F. Comments: (Any information that would be helpful in determining educational needs)

Date of Exam _____ Signature of Examiner_____

Degree _____

Address_____

Phone # _____