CLARKSVILLE MONTGOMERY COUNTY SCHOOL SYSTEM

VISION SERVICES REFERRAL INFORMATION

Student's Name: _____ DOB: _____ Age_____

Teacher / Program: _____ School: _____

What learning situations do you feel need the support of vision services? (Please be specific)

_____

_____

Have any interventions been attempted? □ yes □ no

Classroom Intervention Attempted: From (date) _____To (date) _____

(Check all interventions attempted)

_____ classroom placement

_____ enlarge materials

_____ more lighting – less lighting

_____ white chalk on dark board / dark marker on white board

_____ decrease class work

_____ extra test / assignment time

_____ student tapes classroom lectures or discussions

_____ desk copies of teachers' notes or lectures

_____ student given oral rather than written tests

_____ peer tutoring provided

_____ student allowed to copy another student's class notes

_____ accept homework papers, etc. typed by the student or dictated by student and recorded by someone else

_____ bold lined paper or raised lined paper provided

_____ allow child to "see" through touch

_____ add texture to objects / activities

_____ use pictures or objects that are bright, shiny or have sound

_____ use verbal descriptions when telling stories

_____ use tactile and auditory stimulation to affect motivation

_____ use books with stick on shapes to illustrate size, shape, top and bottom and left right

_____ use sounds as clues to initiate movement / attention

_____ hand-over-hand instruction

_____ eliminate all non-essential distractions

_____ manipulate lighting for maximum viewing

_____ other intervention – specify:_____

Results of interventions attempted: (Please attach results of teacher interventions used to this page)