

**ACCESS TO LEARNING LOW VISION CLINIC**

**PARENTS/CAREGIVER**

**LOW VISION PRE-EXAMINATION INFORMATION**

Today’s Date: Name of Child:

Date of Birth:       Sex:  M  F

Parent/Guardian name:

Mailing Address:       City, State, Zip:

Primary Phone:

* With whom does the child reside? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Mother, Father, Guardian (Please specify))

* Is an interpreter needed at the clinic?   Yes  No
* Name of child’s primary eye care doctor:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of child’s last eye exam:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What is the cause of the visual impairment?      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* At what age did the visual impairment occur?      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does anyone in your family have similar visual problems?      \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is your child bothered by glare **or bright sunlight**?  No  Yes
* What type of glare protection does your child use regularly?     \_\_\_\_\_\_\_\_\_\_\_\_
* List aids your child uses to help them see better:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does your child have any other medical conditions?     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does your child have hearing loss?  No  Yes If yes, please describe the level of hearing loss.     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* List the medications your child is currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* List any special medical treatments or surgeries he or she has had or is receiving:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is your child currently receiving orientation and mobility training?  No  Yes
* List any devices or aids your child uses for mobility (e.g. rigid white cane, adaptive mobility device, monocular telescope. etc):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What would you like to learn from this evaluation?

**To submit form electronically:** save this file, fill in fields, save final file to your computer; and email to [margarethidalgo@nmsbvi.k12.nm.us](mailto: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