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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