California
Department of
Education

California School for the Blind
500 Walnut Avenue
Fremont, CA 94536
(510) 794-3800

Tom Torlakson
State Superintendent of
Public Instruction

Dr. Sharon Sacks
Superintendent

CSB Low Vision Clinic Referral Packet

The California School for the Blind in collaboration with the University of California at Berkeley School of Optometry provides low vision examinations and optical devices to students who have low vision in California schools and have been identified as eligible for services for students who are visually impaired. The exams and devices are provided free of charge through the California Department of Education.

We see students who are able to respond in a clear manner to verbal directions and questions involved in a typical low vision examination. Very young children and those who have difficulty with consistent, clear communication may be better served at the Special Visual Assessment Clinic at UC Berkeley, (510) 642-2020.

To make a referral, please submit the following:

____Low Vision Clinic Referral Application
____Patient Information Form
____Permission Form/Photographic Release Form
____Vision Report from eye care professional (optometrist or ophthalmologist) (from within the past three years, if possible)
____IEP Cover Sheet showing that the student qualifies for vision services

The CSB Low Vision clinic is held in Fremont on two or three Wednesdays each month and in San Diego one Monday each semester. Appointments will be scheduled upon return of all required information and in the order that they are received.

We require that the student's teacher of the visually impaired or orientation and mobility specialist attend the appointment, and we count on this professional to encourage parents and others concerned with the student to attend as well.

If you have questions, please call Shelby Zimmerman at (510) 936-5526 or email szimmerman@csb-cde.ca.gov. We look forward to working with you, your students, and the students' families to meet the students' low vision needs.

Please mail the completed referral packet to:
Shelby Zimmerman
California School for the Blind
500 Walnut Ave.
Fremont, CA 94536

Via email: szimmerman@csb-cde.ca.gov   By fax: (510) 794-3813 Attn: Shelby Zimmerman

California School for the Blind
UC Berkeley School of Optometry
LOW VISION CLINIC

Date of referral________________________________

Student: ____ Birthdate: _________________________

Parent(s) or Caregiver(s): ____

Address: ____
(Street) (City) (State) (Zip)

Home Phone: (_____)_______________________ Work Phone: (_____)_______________________

Cell Phone: (_____)_______________________ Email______________________________________

Is the student: visually impaired? _____ blind? _____ deaf-blind? _____

Cause of vision impairment or blindness: ____

Please list and describe any additional or suspected disabilities: ______________________________

____

Student's Primary Language: School? ___________________ Home? ___________________

Student's School: ____________________________ Phone: (_____)__________________________

District of Residence:__________________________ Phone: (_____)__________________________

SELPA: _____________________________________ County: ________________________________

Name of TVI or O&M specialist making referral: ____

Employer: ____ Role: ____________________________

Address:____
(Street) (City) (State) (Zip)

Work Phone: (_____)__________________________ Cell: (_____)____________________________

Email: ____

Patient Information Form
California School for the Blind
Low Vision Clinic

Name: ____________________________ Birthdate: _______________ Referral date: _______________

Last eye examination: Approximate Date: ______________ Doctor: ____________________________

Are you currently under treatment by an eye doctor? ______ Who?____________________________

Has your vision changed in the past six months? ____

Please describe devices you use: eyeglasses ______________ magnifier ________________________

monocular telescope _________________ electronic low vision device ___________________________

computer software________________________ writing tools __________________________________

What is your primary learning medium? ____

What other learning media do you use? ____

Check which tasks are difficult for you due to your visual impairment:

reading paperbacks	_______	reading signs	_______
seeing changes in terrain	_______	doing math sheets	_______
cooking	_______	reading white board	_______
shopping	_______	reading overheads	_______
recognizing faces	_______	using maps/graphs	_______
traveling in dimly lit areas	_______	playing video games	_______
handling glare	_______	watching TV	_______

other (describe) ____

Which visual tasks would you like help with? ____

____

What medications do you take regularly? ____

____

PERMISSION FORM
Low Vision Clinic
University of California, Berkeley
California School for the Blind

I give my permission for ______________________________________ to have a
(student's name)
low vision examination administered by staff of the University of California, Berkeley, School of Optometry. Although it is unlikely, this examination may include dilation of my student's eyes if necessary to check eye health. The results of the examination will be shared with parent/guardian(s), the student's local school representatives, and California School for the Blind staff. Vision and education professionals may observe the examination as a part of their training programs. Data collected may be used in and published as research. My student's confidentiality will be maintained.

____
Parent/Guardian Name (or Student Name if over 18) (Please Print)

____
Parent/Guardian Signature (or Student Signature if over 18)

Date: ____________________________

Address: _______________________________ Phone Number: _______________________
____
____

PHOTOGRAPHIC RELEASE*

I give my permission for ____ to be
(student's name)
photographed, recorded, and /or videotaped for the purposes of assessment and for use in training other professional staff, parents, and students.

____
Parent/Guardian Name (or Student Name if over 18) (Please Print)

____
Parent/Guardian Signature (or Student Signature if over 18)

Date: ____________________________

Address: _______________________________ Phone Number: _______________________
____
____

*Permission to photograph is not required for referral for a low vision examination