California
Department of
Education

Tony Thurmond
State Superintendent of
Public Instruction

Gina Ouellette
Superintendent

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

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 professions (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 once per 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.

Please mail the completed referral packet to:

Low Vision Clinic
California School for the Blind
500 Walnut Avenue
Fremont, CA 94536

Via email: csb.lowvision@csb-cde.ca.gov
By fax: (510) 794-3993 Attn: Low Vision Clinc

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

Date of Referral

Student: Birthdate:

Parent(s) or Caregiver(s):

Address:

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: in School? at Home?

Student's School: Phone:

District of Residence: Phone:

SELPA: County:

Name of TVI or O&M Specialist making referral:

Employer: Role:

TVI Address (hard copies of Low Vision report will be sent here)

Work Phone: Cell Phone:

Email:

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

Name: Birthdate: Referral Date:

Last Eye Examination:

Approximate Date of Exam:

Doctor:

Are you currently under treatment by an eye doctor?

◯ Yes If Yes, Who?

◯ No

Has your vision changed in the past six months? ◯ Yes ◯ No

Please describe devices you use:

eyeglasses
monocular telescope
computer software
magnifier
writing tools
electronic low vision device

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	☐ traveling in dimly lit areas
☐ seeing changes in terrain	☐ doing math sheets	☐ handling glare
☐ cooking	☐ reading white board	☐ playing video games
☐ shopping	☐ reading overheads	☐ watching TV
☐ recognizing faces	☐ using maps/graphs	☐ other (describe)

Which visual tasks would you like help with?

What medications do you take regularly?

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

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 parents/guardians, 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.

Printed Parent/Guardian Name (or Student Name if over 18)

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

Date:

Address: Phone Number:

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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.

Printed Parent/Guardian Name (or Student Name if over 18)

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

Date:

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