Children's Low Vision Project of British Columbia (CLVP-BC)

Educator Form

Student Name (First, Last)

Student Date of Birth

Referring Educator's Name

Role/Relationship to Student

Referring Educator's Email Address

Phone Number

How long have you worked with the student?

Student Grade Level

Section A: Academic Profile

Student Academic Level (Grade equivalent)

Does the student follow a modified program? No

School Name:

School Address:

Section B: Educational Team Profile

Which school or district personnel will accompany the student to CLVP?

Name | Role

Name | Role

Name | Role

Please send this completed referral as an email attachment to clvp@prcvi.org.

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Please indicate the supports in place on the student's educational team (check all that apply):

☐ OT ☐ PT ☐ Speech (SLP) ☐ Orientation & Mobility ☐ Learning Support

Is the student supported by an Educational Assistant (EA/CEA/SEA)? No

If yes, for how many hours per week?

Section C: Student Access Profile

What is the student's primary learning medium?

☐ Braille ☐ Standard Print ☐ Large Print ☐ Audio ☐ Other _____

What secondary media does the student use to access learning content?

☐ Braille ☐ Standard Print ☐ Large Print ☐ Audio ☐ Other _____

Please use this space to provide additional details on learning media.

Is the student registered with PRCVI? Yes

If yes, what is their registration status with PRCVI? Full Registration

Does the student wear spectacles (glasses)? Yes

If yes, how frequently are spectacles worn at school?

Does the student use optical devices at near? Yes

Does the student use optical devices for distance viewing? Yes

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Please detail the low vision devices currently used by the student:

	Type/Description (e.g., Bar Magnifier with yellow line)	Mag. Power (e.g., 2X)	Provided by:
Magnifier			CLVP
			CLVP
			CLVP
Monocular			CLVP

Please briefly describe how the student uses these devices and how often each device is used (e.g., daily, weekly, monthly).

Please detail the access technology currently used by the student:

Type/Description (e.g., Room viewing system)	Name/Model (e.g. DaVinci)	Provided by:
		SET-BC
		SET-BC
		SET-BC

Please briefly describe how the student uses this technology and how often each device is used (e.g., daily, weekly, monthly).

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Section D: Orientation and Mobility (O&M) Programming

If the student currently receives O&M services, please ask the O&M Specialist to complete this section.

O&M Specialist Name:

How often do you work with the student?:

What tools, devices, and/or apps does the student currently use in their O&M lessons?

What O&M goal(s) is the student currently working to achieve?

What longer-term O&M goal(s) is the student hoping to achieve in the year(s) ahead?

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Section E: Goals for CLVP Experience

Based on the experience of the educational team, what challenges (e.g., learning, socio-emotional, mobility) does the student experience at school related to their vision loss?

What does the student's educational team hope to gain from the CLVP assessment process? Please list specific goals.

Please use this space to provide any additional information about the student's profile and/ or suggestions for how to make this a productive clinic experience for the student and their educational team.

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