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

Student Referral Form

Referral Date

Student Name (First, Last)

Referral Submitted By

Relationship to Student

Student Information

Please complete all fields. Incomplete referral forms will not be considered.

Grade Level

Academic Level

School District/Education Authority

Name of Teacher of Students with Visual Impairments (TSVI)/Consultant

TSVI/Consultant Email Address

TSVI/Consultant Phone Number

Is This a New Referral to CLVP? (Yes/No)

Parent/Guardian Name

Parent/Guardian Email Address

Parent/Guardian Phone Number

Student's Home City/Town

Preferred Region for Clinic Visit

Please send this completed referral as an email attachment to clvp@prcvi.org. In the same email, include a digital copy of the student's most recent vision assessment report.

CLVP is hosted by the Provincial Resource Centre for the Visually Impaired (PRCVI)

PRCVI

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Student Visual Profile

OD Acuity

OS Acuity

OU Acuity

Name of Visual Condition

List of Secondary Conditions (if applicable)

Date of Most Recent Vision Assessment

Who Conducted This Assessment?

Is the Student Registered with PRCVI? (Yes/No)

Is the Student Able to Manage Optical Aids (Yes/No)

Is the Student Able to be Tested with Symbols or Letters? (Yes/No)

What is the Student's Current Reading Medium?

Referral Rationale

Please Provide a Rationale for This Referral. Why Should the Student Attend CLVP?

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PRCVI