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 • Fax (510) 794-3818

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 can respond clearly to verbal directions and questions asked in a typical low-vision examination. Very young children and those with consistent, clear communication difficulties 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 (pg. 2)**
- ☐ **Application Patient Information form (pg. 3)**
- ☐ **Permission Form/Photographic Release form (pg. 5)**
- ☐ **Vision Report from eye care professionals (optometrist or ophthalmologist)**
- ☐ **IEP Cover Sheet showing the student qualifies for vision services**

The CSB Low Vision Clinic is held in Fremont on two or three Wednesdays each month. Travel clinics can be coordinated for individuals in areas over a three-hour drive from our CSB campus. Appointments will be scheduled upon the 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 participate as well. Interpretation services are available for families and students as needed, we can arrange Zoom sessions for those unable to attend in person.

Please mail the completed referral packet to the following address:

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 Clinic

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

Date of Referral:			
Student:		**Birthdate:**	
Preferred Pronouns:	◯ She/Her/Hers ◯ He/Him/His ◯ They/Them/Theirs ◯ Other:		
Parent(s) or Caregiver(s):		**Phone Number:**	
Email:			
Primary Language at Home:		**Interpreter Needed?**	Yes ◯ No ◯
Student's School:			
Student's District:			

TVI/O&M Name:		**Employer:**	
Email:		**Phone:**	

Cause of vision impairment or blindness:	
List and describe any additional or suspected disabilities:	
IEP Eligibility	Primary:
	Secondary:

Last eye exam date:	
Are you currently under treatment by an eye doctor?	Yes ◯ No ◯
Eye health doctor:	
Have you experienced changes in your vision in the past six months? Describe.	Yes ◯ No ◯

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LOW VISION CLINIC

What is your primary learning medium (print, digital print, braille, auditory)?

What is your secondary learning medium (print, digital print, braille, auditory)?

Please describe the devices you use:

Eyeglasses	
Monocular telescope	
Computer	
Accessibility software	
Near vision devices	
Distance vision devices	
Other (phone, tablet):	

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 worksheets	☐ Handling glare
☐ Cooking	☐ Reading a whiteboard	☐ Playing video games
☐ Shopping	☐ Reading material presented on a board	☐ Watching TV
☐ Recognizing faces	☐ Using maps/graphs	☐ Other:

Which visual tasks would you like the most help with?

What medications do you take regularly?

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Is there anything else you would like the CSB Low Vision Clinic team to know about this student?

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

I give my permission for _____(student name) to have a 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 examination results 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:_____ Phone Number: _____

Address: _____

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PHOTOGRAPHIC RELEASE

I give my permission for _____to be 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

August 2024