www.aiu3.net/visionreferral

Blind and Visually Impaired Support Program

REFERRAL FOR VISION SUPPORT SERVICES

PLEASE DO NOT OBTAIN A SIGNED PERMISSION TO EVALUATE / RE-EVALUATE (PTE /PTRE) FORM UNTIL REQUESTED BY THE AIU VISION OFFICE.

Student Last Name: _____ Student First Name: _____ DOB: _____

Grade: _____ District: _____ Building: _____

Parent/Guardian Name: _____

Parent/Guardian Street Address: _____

City: _____ State: _____ Zip: _____

Parent Home Phone #: _____ Parent Cell Phone #: _____

Parent Email: _____

District Contact Name: _____

District Contact Email: _____ District Contact Phone #: _____

For Students Transferring In Who Receive Vision Services with a Current IEP:
Transferring from within PA ☐ no ☐ yes include current RR/IEP with referral
Amount of Vision Service denoted on student's current IEP: _____
Amount of Orientation and Mobility Service denoted on student's current IEP: _____

Please explain the reason for the referral:

Check any services that the student currently receives and/or is currently being evaluated to receive

	Currently receives	Currently being evaluated
Gifted Support	☐	☐
Blind/Visually Impaired Support	☐	☐
Speech and Language Support	☐	☐
Deaf and Hard of Hearing Support	☐	☐
Learning Support	☐	☐
Life Skills	☐	☐
Physical Support	☐	☐
Emotional Support	☐	☐
Autistic Support	☐	☐
Multiple Disabilities Support	☐	☐

District Liaison/Supervisor Name: _____ Date: _____

Submitting this form will be considered as authorization to proceed with the referral evaluation.

EMAIL ANY AVAILABLE MEDICAL EYE REPORTS FOR REVIEW

Email this form (along with current eye report, if available) to bvispreferral@aiu3.net or fax to (412) 851-1057.

For questions call (412) 394-7364.

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