

**INITIAL REFERRAL FORM**  
**VISION IMPAIRED PROGRAM**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL DISTRICT OF RESIDENCE: \_\_\_\_\_

PARENT(S) NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: \_\_\_\_\_

NATURE OF VISION PROBLEM: \_\_\_\_\_

VISION ACUITY (if known):

WITHOUT CORRECTION: \_\_\_\_\_ WITH CORRECTION: \_\_\_\_\_

RIGHT EYE: \_\_\_\_\_ LEFT EYE: \_\_\_\_\_ BOTH EYES: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

**PERSON MAKING REFERRAL:**

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Return to:**

**Barbara Cassel**  
**Appalachia Intermediate Unit 8**  
**609 Georgian Place**  
**Somerset, PA 15501**