



STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Student Referral Form

Date of Referral: _____

Name of Student: _____ Age: _____ DOB: _____ Current Grade: _____ Gender: _____

Current School Attending: _____ District: _____

School Address: _____ City: _____ State: _____ Zip: _____

Referred By: _____

Contact Information:

Relationship: _____

Phone: () _____

Email: _____

Mailing Address: _____

When will the IEP team have a meeting to change placement?

Team Contacts:

Teacher of Visually Impaired:

Phone: () _____

Email: _____

O&M Instructor:

Phone: () _____

Email: _____

Special Ed Teacher:

Phone: () _____

Email: _____

Other: _____

Phone: () _____

Email: _____

Please share with us why you are referring this student:

Please attach following information:

1. Copy of the current IEP
2. Copy of the current 3 Year Evaluation
3. Recent Ophthalmological Report – within the past 12 months. (Dr. may fax directly to WSSB)

Mail all documents to:
 Washington State School for the Blind
 Attn: Enrollment
 2214 E. 13th Street
 Vancouver, WA 98661

Please contact Sean McCormick, Principal at 360-947-3309, if you have further questions.



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Ophthalmologic Examination

(Must be completed by a Doctor. You can use this form or have your Doctor send their own report.)

Student Name: _____

Date of Birth: _____

History:

Current Visual Diagnosis: _____

Onset: _____

Related Medical Conditions: _____

Current Medications: _____

Drug Allergies: _____

Findings:

Anterior Segment Eye Health:

Posterior Segment Eye Health:

Eye Pressure: OD _____ OS _____

Visual Fields: normal _____ restricted _____

If restricted: Please attach copy of fields Test.

OD _____

OS _____

Refractive Error: Distance OD _____ OS _____

Distance Acuity through best refraction: OD _____ OS _____ OU _____

Near Acuity through best refraction: OD _____ OS _____ OU _____

Medical Prognosis:

_____ Stable _____ Slowly Progressive _____ Rapidly Progressive _____ Improving

Needs recheck in _____ 6 months _____ 1 year _____ 2 years _____ other _____

Physician's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Physician's Signature _____ Date _____