RHODE ISLAND COLLEGE
PAUL V. SHERLOCK CENTER
ON DISABILITIES

Referral for Services

Referral Date _____/_____/_____

Student Name: ________________________________ DOB:____/_____/_____

Home Address: ____________________________________ Zip Code: ________

Home Phone: _______________________ Cell Phone: ____________________

School: ___________________________________ Phone: _________________

Case manager: ____________________ Preferred contact: _________________

District Authorizing Agent: ____

Preferred contact: ____

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Has student/family been referred to Rhode Island Services for the Blind and Visually Impaired? ____yes ____no ____not sure

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Checklist of Items to be included in the referral packet:

1. Reason for Referral (please check)

___ Functional Vision Assessment ____ TVI services
___ O&M Assessment ___ O&M services
___ Learning Media Assessment

2. ___ Consent to Evaluate
3. ___ Eye Report from Ophthalmologist (required)
4. ___ Eye Report from Optometrist
5. ___ Guardian Release
5. ___ Current IEP
6. ___ Medical Reports
7. ___ Other reports (OT, PT, etc)

****please feel free to add any additional information**

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Date received ____/_____/_____ by: _______