# The Children's Vision Rehabilitation Project

*Pre-Examination Report from the **PARENT** of the visually impaired child*

| Location: | Date: | Time: | Forms due at least 2 weeks prior to appointment |
|---|---|---|---|
| _____ | _____ | _____ | |

**THIS FORM MUST BE COMPLETED & RETURNED TO KEEP YOU CHILD'S APPOINTMENT**

Name of Child _____ Date of Birth:_____Social Security #: _____ - _____ - _____

Parent or Guardian: _____ Relationship to Child: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

County: _____

**MEDICAL HISTORY**

Is your child in good physical health? ☐ Yes ☐ No (*please specify*_____)

List the medications your child is currently taking and any special medical treatments: _____

_____

Does your child experience difficulties at ☐ school, due to vision ☐ home, due to vision?

Please describe:_____

**VISUAL HISTORY**

Name of Eye Doctor:_____ Date of last appointment:_____

Address of Doctor: _____

_____ Phone #:_____

What is the cause of your child's visual loss?_____

Explain any treatment, medication, or surgery related to your child's eye condition: _____

_____

At what age did your child's vision loss occur? _____

Which eye seems to be your child's better eye? ☐ Right ☐ Left ☐ No difference

Explain any recent changes in your child's vision: _____

_____

**VISUAL FUNCTIONING**

Does your child watch TV? ☐ Yes ☐ No at what distance? _____

Does your child see better or more comfortable on: ☐ bright sunny days OR ☐ overcast/cloudy days

Is your child bothered by glare? ☐ Yes ☐ No

Does your child use sunglasses, a visor, or a hat? ☐ Yes ☐ No

Does your child use a magnifying glass or other devices for reading? ☐ Yes ☐ No

Does your child use any of the following:

☐ Braille ☐ Talking Books ☐ Cassettes ☐ Readers ☐ Tapes ☐ Computers ☐ Closed-Circuit TV

**MOBILITY**

Can your child independently:

| | | |
|---|---|---|
| Travel in familiar buildings (eg. home, friends home, school, school building? | ☐ Yes | ☐ No |
| Travel immediate area around your home (eg. backyard, front yard)? | ☐ Yes | ☐ No |
| Negotiate steps/curbs? | ☐ Yes | ☐ No |
| Travel in unfamiliar places without tripping or bumping? | ☐ Yes | ☐ No |
| Cross quiet residential streets, if age appropriate? | ☐ Yes | ☐ No |
| Find a favorite food or drink in a convenience store? | ☐ Yes | ☐ No |
| Has your child received orientation and mobility services? | ☐ Yes | ☐ No |
| Do you have concerns about your child's ability to travel independently? | ☐ Yes | ☐ No |

**OCCUPATIONAL THERAPY**

Does your child receive OT services? ☐ Yes ☐ No If yes, how often and for what? _____

| Can the your child independently (please T) | Yes | No | Explain |
|---|---|---|---|
| Eat / drink a typical meal or snack? | ☐ | ☐ | _____ |
| Button, zip, snap? | ☐ | ☐ | _____ |
| Brush teeth, use bathroom? | ☐ | ☐ | _____ |
| Do writing tasks? | ☐ | ☐ | _____ |

What specific concern do you have about your child's ability to complete his/her self-care, participate in school work or their ability to follow/remember instructions?_____

_____

**OTHER INFORMATION**

What do you see as employment opportunities for your child's future? _____

_____

**In order to provide the best care for your child, CVRP collaborates with other agencies such as the Instructional Resource Center, WV School for the Deaf & Blind, WV State Department of Education, and your county Local Educational Agency. If you would NOT like your child's report to be forwarded to a particular agency, please indicate that agency here:**

☐**Please DO NOT send my child's report to:** _____

Your child's low vision report will be mailed to you and to the county board of education. Please list additional persons or offices that you may want this report to be sent: **(ADDRESSES MUST BE COMPLETE)**

_____

Name Address City, State, Zip

_____

Name Address City, State, Zip

_____

**Parent/Guardian Signature**

**Return this form at least TWO WEEKS prior to the clinic date to:**

Paula Lang, Program Coordinator
Children's Vision Rehabilitation Project
WVU Eye Institute
PO Box 9193
Morgantown, WV 26506-9193
Phone (304) 598-6965 Fax (304) 598-6928
langp@wvuhealthcare.com

**SUBMIT ELECTRONICALLY**

CVRP
WestVirginiaUniversity
Children's Vision Rehabilitation Project