



Assistive Technology Referral Form
Vision

Student's Name: _____ Completed by: _____
(Vision Teacher or Nurse)

Date of last vision exam: _____ Re-exam Date: _____

Diagnosis: _____

Field of Vision: _____

Acuity: _____

Prognosis: _____

Does the student have fluctuating visual abilities? Y N Describe: _____

What is the student's smallest readable size of print? 9, 10, 12, 14, 16, 18, 20, 24 _____

What is the student's preferred size of print? _____

Describe the student's means of maintaining his/her place when reading: _____

Describe the student's ability to use regular textbooks and workbooks: _____

Describe the student's ability to read and copy from the blackboard: _____

Does the student require extra time to complete assignments ? Y No

In what subject areas is time needed and how much? _____

At what distance does the student hold reading material? _____

Angle? _____

Does student move page or material to view? Y N

Describe: _____

Comments: _____