



# Blind and Visually Impaired Support Program REFERRAL FOR VISION SUPPORT SERVICES

**IMPORTANT:**

**DO NOT OBTAIN A SIGNED PERMISSION TO EVALUATE / RE-EVALUATE (PTE /PTRE) FORM UNTIL REQUESTED BY THE AIU VISION OFFICE.**

Student Last Name: Student First Name: DOB:

Grade: District: Building:

Parent/Guardian Name:

Parent/Guardian Street Address:

City: State: Zip:

Parent Home Phone #: Parent Cell Phone #:

Parent Email:

District Contact Name:

District Contact Email: District Contact Phone #:

<p>For Students Transferring in who receive Vision Services with an existing IEP</p> <p>Transferring from within PA    no    yes include current RR/IEP with referral</p> <p>Amount of Vision Service denoted on student's current IEP:</p> <p>Amount of Orientation and Mobility Service denoted on student's current IEP:</p>
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Please explain the reason for the referral:

**Check any services that the student currently receives and/or is currently being evaluated to receive**

	Currently receives	Currently being evaluated
Gifted Support		
Blind/Visually Impaired Support		
Speech and Language Support		
Deaf and Hard of Hearing Support		
Learning Support		
Life Skills		
Physical Support		
Emotional Support		
Autistic Support		
Multiple Disabilities Support		

District Liaison/Supervisor Name: Date:

**Submitting this form will be considered as authorization to proceed with the referral evaluation.  
EMAIL ANY AVAILABLE MEDICAL EYE REPORTS FOR REVIEW**

Email this form (along with current eye report, if available) to [bvispreferral@aiu3.net](mailto:bvispreferral@aiu3.net) or fax to (412) 851-1057.

For questions call (412)