



Washtenaw ISD

A REGIONAL EDUCATIONAL SERVICE AGENCY

Referral for Special Education Services Visually Impaired

STUDENT INFORMATION

Today's Date: _____

Student Last Name	Student First Name	Birthdate/Age	M/F
Student Address	City/Zip	Grade/School	
Resident District	Attending District	Teacher/Case-manager Name (contact info)	
Parent/Guardian Name(s)	Home Phone	Cell Phone	Email

REASON FOR REFERRAL (attach additional information if necessary)

Does the student have a current IEP? YES NO

SERVICES BEING REQUESTED – please describe the type of services being requested below.

Assessment:
Consultation:
Orientation and Mobility:
Other Vision related services:

Please attach most recent ophthalmological report.

REFERRED BY:

Name/Title:	Phone/Email:

Received (WISD): Name _____ Date _____