RI Early Intervention
Vision Services Referral Form

Child's Name: Gender: ☐ M ☐ F ☐ Non-Binary ID#:

DOB: Age: Referral Date:

Parent/Guardian Name(s)

Address

Home Phone: Cell Phone:

Languages spoken in the home:

Service Coordinator: EI Program:

Service Coordinator (check preferred method of communication)

☐ Phone: ☐ Email: ☐ Text:

Additional EI providers (name & role):
Briefly describe the family's and/or EI providers concerns about this child's vision and overall development:

Eye Condition:	Additional Diagnosis:

When making a referral for Vision Services, the following must be provided:

- ☐ Vision Services Referral Form*
- ☐ Ophthalmology Report (if available)
- ☐ Signed copy of authorization to release/obtain information to/from RIVESP (RIVESP manages the referral process)*
- ☐ Signed copy of authorization for the Vision Service Provider to release/obtain information to/from child's ophthalmologist*
- ☐ Copy of IFSP Evaluation Summary, Outcomes, Services, and Vision Assessment*
- ☐ Other reports as needed

To help match this child/family with the best available Vision Service provider, please indicate the days and times this family is typically available for home visits (e.g. any day 10am- 4pm, only Tues and Thurs after 3, etc).

If this child is seen at a location other than his/her home address, please indicate address here:

Who is the caregiver at this address?

Fax or email referral and other required information to Stefanie Lafleur Davit at the Paul V. Sherlock Center on Disabilities at: Fax: 456-1979 or email sdavit@ric.edu Tel: 456-8752. *Ref Rcvd.*