RI Early Intervention
Vision Services Referral Form

Child's Name: ID #: DOB: Date:

Gender: ☐ Male ☐ Female ☐ Non-binary Age:

Parent/Guardian Name(s):

Address:

Home Phone #: ☐ Preferred Cell Phone #: ☐ Preferred

Languages spoken in the home:

Service Coordinator: EI Program:

SC Phone: SC Email:

Check preferred method of communication: ☐ Phone ☐ Email ☐ Text

Additional IFSP Team Members (Name and Role):

Briefly describe the family's and/or EI teams 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:

- ☐ Ophthalmology Report
- ☐ Signed copy of consent to release/obtain information from child's ophthalmologist
- ☐ Copy of IFSP including evaluation summary, outcomes, services and vision assessment

Include other information and reports as needed

To help match this family with the best available Vision Services provider, please indicate the days and times this family is typically available for home visits (e.g. any day after 3, only Tues and Thurs between 3 and 5, etc.)

If this child is seen at a location other than their home, please indicate caregiver name and address:

Email referral and other required information to Patricia Maris at the Paul V Sherlock Center on Disabilities at RI College @ pmaris@ric.edu Phone: 456-4735.
Referral Received: