Paul V. Sherlock Center
On Disabilities / Rhode Island College

600 Mt. Pleasant Ave.
Providence, RI 02908-1996
401-456-8072
TTY: 711
Fax: 401-456-8150

Rhode Island Vision Education & Services Program
Referral Request

Student Information:
Student Name: _____ DOB: ___/___/___ Grade: ___
Student's Visual Diagnosis: _____
School District: _____ Date of Request: ___/___/___
School Name: _____
School Address: _____
School Hours: _____

School Contact Information:
Case Manager Name: _____
Case Manager Email: _____ Phone: _____
Preferred Contact Name (if different from above): _____
Email: _____ Phone: _____

Parent/Guardian Information

Name(s): _____
Home Address: _____
Phone: _____ Email: _____

Has student/family been referred to Rhode Island Services for the Blind and Visually Impaired? Yes ☐ No ☐ Unknown ☐

NOTE: THIS FORM IS NOT A MEMORANDUM OF AGREEMENT (MOA)
RIVESP will send a MOA once a complete referral request is received.

Please follow these procedures:

1. Indicate the ***type of service*** you are requesting
2. Have this form **signed** by your Director of Special Education
3. Return the ***completed referral request and forms with supporting documents*** to:

Stefanie Davit, RI Vision Education & Services Program Coordinator

Rhode Island College
Paul V. Sherlock Center on Disabilities
600 Mt. Pleasant Avenue
Providence, RI 02908-1991

Phone: 401.456.8752
Fax: 401.456.8150
Email: sdavit@ric.edu
www.sherlockcenter.org

TYPE OF SERVICE REQUESTED

1. ASSESSMENTS

Please place a check next to the requested assessment:

☐ Assessment by a Certified Teacher of the Visually Impaired (TVI)
- ☐ Functional Vision Assessment (FVA) **only**
- ☐ Functional Vision Assessment & Learning Media Assessment (FVA/LMA)

☐ Assessment by a Certified Orientation & Mobility Specialist (COMS)
☐ Consultation/Screening by a Certified Teacher of the Visually Impaired (TVI)
☐ Consultation/Screening by a Certified Orientation & Mobility Specialist (COMS)

2. DIRECT AND/OR CONSULTATIVE SERVICES

Note: Student must have a current assessment. This is typically requested if a student currently receives services and is new to your district.

Please place a check next to each of the requested services:

☐ Teacher of the Visually Impaired (TVI)
- ☐ Direct service
- ☐ Consultative service

☐ Certified Orientation & Mobility Specialist (COMS)
- ☐ Direct service
- ☐ Consultative service

3. CHECKLIST OF ITEMS TO BE INCLUDED IN THE REFERRAL REQUEST

☐ District "Consent to Evaluate" Form or Prior Written Notice
☐ Eye Report from Ophthalmologist (**required**)
☐ Eye Report from Optometrist
☐ RIVESP "Authorization for Release of Confidential Information" Form
☐ Current IEP or 504 Plan (if applicable)
☐ Medical Reports (if applicable)
☐ Other reports (OT, PT, Educational, etc.)

Please add any additional information that may be helpful to our providers.

DISTRICT APPROVAL (REQUIRED)

Signature, Director of Special Education _____ Date _____

Address: _____

Phone: _____ Email: _____

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Authorization for Release of Confidential Information

Date:		**Name:**_____	**DOB:**	
Address: _____			**Phone:**	
LEA/School:_____			**Grade:**	

I HEREBY AUTHORIZE THE RHODE ISLAND VISION EDUCATION AND SERVICES PROGRAM

TO: ☐ RELEASE ☐ EXCHANGE WITH ☐ OBTAIN FROM ☐ VERBALLY EXCHANGE WITH

AGENCY/SCHOOL/INDIVIDUAL

School/Agency:	_____
Address:	_____
Phone/Fax/Email:	_____

THE FOLLOWING CONFIDENTIAL INFORMATION:

☐ Academic Records	☐ Educational	☐ Social History	☐ Child Outcomes Summary Forms
☐ Medical/Health Records	☐ Psychological	☐ Clinical/Psychiatric	☐ Teacher/Therapist Notes & Observations
☐ IEP ☐ 504 Plan ☐ IFSP	☐ Speech/Language	☐ Meeting minutes	☐ Neuropsychological/Neurodevelopment
☐ Eligibility Determination Form	☐ Occupational Therapy	☐ Physical Therapy	☐ Audiological
☐ Other: _____			

FOR THE PURPOSE OF: ☐ Educational Planning ☐ Other:_____

Within the educational setting, the Family Educational Rights and Privacy Act (FERPA) govern the confidentiality and disclosure of educational records. This form is used to request the release of information to assist in providing educational programs and services to the named student. This consent will have a duration of no longer than one (1) year from the date of this form. I understand that I may withdraw my consent at any time. The revocation must be in writing and received by the Paul V. Sherlock Center on Disabilities, 600 Mt. Pleasant Avenue, Providence, RI, 02908. Therefore, I release RIVESP and its employees from all liability arising from this disclosure. I understand that a withdrawal will not apply to information already released in response to this authorization. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign the authorization. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

This release is valid through _____ unless permission is withdrawn sooner, in writing, by the undersigned.

Signature: _____ Relationship: _____ Date: _____

Printed Name: _____

Witness: _____