CASE
excellence through collaboration

Kristen Ninni, Ph.D.
Executive Director

290 Town Center Lane
Glendale Heights, IL 60139-1700

Phone 630-942-5600
Fax 630-942-5601

Dear Educator:

The Cooperative Association for Special Education (CASE) is pleased to provide you the attached Low Incidence Referral Packet for hearing, and vision itinerant services. All enclosed forms may be duplicated.

Referrals to Low Incidence Itinerant Services, as part of the full and comprehensive case study, for individuals 3 to 22 years, are made by the multi-disciplinary team when the student is being considered for special education services or at any time when an educational disability in the areas of hearing, or vision is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please email or mail a copy of the completed itinerant referral to:

Samantha Beck
CASE Vision Itinerant Team Lead
290 Town Center Lane
Glendale Heights, IL 60139
sbeck@casedupage.com

When all referral materials are received, the student will be evaluated by a member of the CASE Itinerant Services diagnostic staff in the low incidence domain requested. There will be a diagnostic evaluation charge for each individual evaluation. The school district will receive a copy of the functional report and be billed for the service upon completion of the evaluation.

CASE staff members are available if needed to in-service school districts regarding the use of these forms. If you have any questions regarding the enclosed information or children considered for evaluation, please feel free to contact us.

Respectfully,

Natalie Heinrich
CASE Administrator of Low Incidence Services

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REFERRAL FOR VISION SERVICES

Student Name_____ Gender: ◯ M ◯ F Date of Birth_____

Home Phone: (_____)_____ Address_____ City_____ Zip_____

Parent(s)/Guardian(s):_____ Work/Cell Phone (_____)_____

Resident District: _____ Resident School: _____

Attending District: _____ Attending School: _____ School Phone: (_____)_____

Attends: ◯AM ◯PM ◯Full Day School Nurse: _____ Nurse Email: _____

Teacher: _____Teacher Email: _____

Vision Functioning Assessment

Upon receipt of the referral a Vision Functioning Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: An Orientation and Mobility Assessment can be requested **if** the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

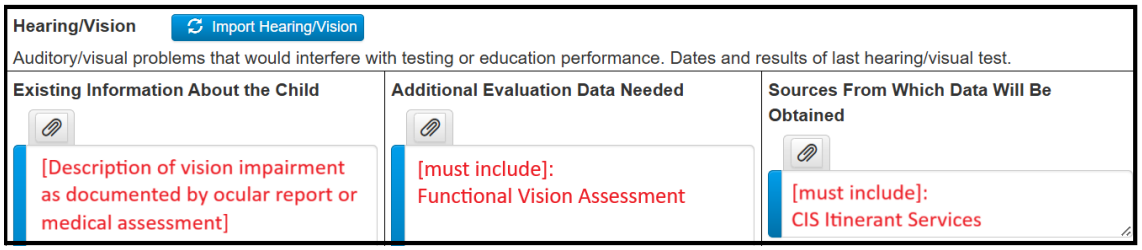
For Orientation and Mobility Services, attach the following form: **https://bit.ly/case-o-and-m**

Documentation REQUIRED with this packet:

☐ Ocular Report ☐ Appropriate administrative signatures (see below) ☐ Educational screening form completed by teachers (see attached)

If proceeding, documentation required prior to scheduling the evaluation:

✓ Domain sheet and parent/guardian consent for evaluation
NOTE: Vision itinerant teachers/evaluators do not *typically* need to be in attendance at the domain meeting.
NOTE: Domain needs to be completed as follows (Embrace screenshot for reference):



✓ Educational information (i.e. IEP, #504 plan)

✓ Class schedule (Jr. High and High School)

Referring Person: _____ Title: _____ Date: _____
Referring Person Email: _____

District Special Education Administrator: _____ Date: _____
Administrator Email: _____

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Educational Screening Form for Students with Suspected or Confirmed Vision Problems

(most be attached to "Referral for Vision Services")

Student Name: _____ Date of Birth: _____ Grade: _____ Primary Language: _____

Current related services: _____

Describe any concerns about this student's ability to use his/her vision:

_____

_____

Please describe the student's ability to utilize vision in the classroom setting for near vision:

_____

_____

Please describe the student's ability to utilize vision in the classroom setting for distance vision:

_____

_____

List Teacher's questions about the student's use of vision:

_____

_____

Does this student wear glasses?	○ YES	○ NO	
In your opinion, does the child need specialized materials?	○ YES	○ NO	
This student's overall academic skills?	○ HIGH	○ AVERAGE	○ LOW
Oral and written language skills?	○ HIGH	○ AVERAGE	○ LOW

Do you feel this student's achievement reflects his/her potential? _____

_____

For modified/assisted programming students, please describe performance, functioning, and school environment:

_____

_____

Additional comments and information: _____

_____

Signed: _____ Title: _____ Date: _____