

## **VISION RESOURCE SERVICES**

### **REFERRAL PROCESS TO REQUEST AN EDUCATIONAL FUNCTIONAL VISION ASSESSMENT FOR A STUDENT WHO IS BLIND OR VISUALLY IMPAIRED AND ATTENDING A FIRST NATION COMMUNITY SCHOOL OR PRIVATE SCHOOL**

Assessments can be requested for a student who is visually impaired/blind, or visually impaired/blind with additional disabilities, and is attending a publicly funded elementary or secondary school within an Ontario District School Board (at no charge).

- A fee for service is applicable for students attending First Nation Community Schools or Private Schools (see attached memo dated March 20, 2001). A request for payment will be made following the completion of the resource visit.
- The attached referral form, parental consent, and fee agreement must be completed and returned when requesting a resource visit.
- A referral form can only be accepted from (and completed by) School personnel. A request for an assessment cannot be accepted from parents, other agencies/professionals (e.g. social workers, hospital personnel, etc).
- The completed referral, signed fee agreement and parental consent may be faxed or mailed to the address indicated on the attached sheet.
- Assessments are completed during regular classroom routines within the student's school.
- We do not provide assessments to students enrolled in Post-Secondary Institutes or French Boards (for French Boards only, contact Centre Jules-Leger at 613-761-9300).

**NOTE:** Assessments and consultations for Students/Children with Deafblindness can be requested by contacting W. Ross Macdonald School, Deafblind Resource Services

**IMPORTANT:** A letter will not be sent indicating the completed referral was received by Vision Resource Services. However, if you wish to obtain verbal confirmation, please contact Ms. Kerri Readings, Secretary, Vision Resource Services. A letter confirming the date/time of the resource visit will be sent after it has been scheduled.

**Ministry of Education**  
 The W. Ross Macdonald School  
 350 Brant Avenue  
 Brantford, ON N3T 3J9  
 Telephone (519) 759-0730  
 Facsimile (519) 759-3677

**Ministère de l'Éducation**  
 l'École W. Ross MacDonald  
 350 Brant Avenue  
 Brantford, ON N3T 3J9  
 Téléphone (519) 759-0730  
 Facsimile (519) 759-3677



**TO:** Principal/Superintendent

**FROM:** Ms. Elizabeth Dunton  
 Principal, Resource Services

**DATE:** May 7, 2009

**RE: First Nation Community Schools and Private Schools - FEE FOR SERVICE**

The W. Ross Macdonald School, Resource Services, provides consultative visits to students who are deafblind or blind/visually impaired who are attending publicly funded elementary/secondary schools in Ontario. Schools which are not publicly funded (e.g. First Nation Community School, Private), will be charged a fee plus expenses (see breakdown below). A request for payment will be made following the completion of the resource visit.

<i>Type of Assessment</i>	<i>Assessment Fee</i>	<i>Payment Required</i>	<i>Additional Expenses</i>
Verbal Consultation (no written report)	\$100.00 (includes GST)	Upon completion of Resource Services visit (invoice will be forwarded for payment)	All other costs (e.g. mileage, accommodation, meals, etc.) pro-rated to the number of students being seen in the same vicinity
Written Report	\$250.00 (includes GST)	Upon receipt of written report (invoice will be forwarded for payment)	See above

**Please check appropriate box, PRINT information below, sign, and return this Memo with completed referral package.**

Verbal Consultation (\$100 plus expenses) **OR**  Written Report (\$250 plus expenses)

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*I agree to the payment of the above fee and expenses*

Mr. or Ms. \_\_\_\_\_  
 Name (Print)

\_\_\_\_\_  
 Title (e.g. Principal, Superintendent)

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

**W. ROSS MACDONALD SCHOOL  
REFERRAL FOR RESOURCE SERVICES**

(For a Student who is Blind or Visually Impaired and Attending an First Nation Community or Private School)

- IMPORTANT:** 1. Indicate School Year in which you want this visit to take place: 2 \_\_\_\_\_ - 2 \_\_\_\_\_ School Year  
 2. Ensure all sections below are completed in full.  
 3. There may be a 1-2 month waiting period after completed forms have been received by WRMS.

**SECTION A - INFORMATION ON STUDENT**

**Name (LAST, First):**

Date of Birth (write in full):

Student attends school during the following times of the day: \_\_\_\_\_ a.m. until \_\_\_\_\_ p.m

Student attends school on the following weekdays:

**SECTION B - INFORMATION ON SCHOOL  
(School Student is Currently Attending)**

Name of School (in full):

Student's Program/Level:

School Address (in full)  
Street Number & Name:

P.O. Box/R.R. #:

City:

Postal Code:

Telephone No.: (      )

Fax No.: (      )

Principal (Mr./Ms.):

Classroom Teacher (Mr./Ms.):

Teacher for the Blind/Visually Impaired (if applicable) - (Mr./Ms.):

**SECTION C - INFORMATION ON PERSON QUESTING REFERRAL  
(Important: Referrals only accepted from School Personnel)**

Name (Mr./Ms.): \_\_\_\_\_ Position: \_\_\_\_\_

Mailing Address if Different from above (do **not** indicate home address) \_\_\_\_\_

Street Number & Name: P.O. Box/R.R. # \_\_\_\_\_

City:

Postal Code:

Telephone No.: (      )

Fax No.: (      )

**SECTION D - REASON FOR REFERRAL**

**Check Appropriate Box(es):**

- Appropriate Adaptive Equipment and/or Software (Note: Training and set-up is not provided)
- Orientation & Mobility (Note: O&M instruction is not provided to student, only assessment)
- Recommendations for Educational Programming
- Transition Year (Elementary to Secondary) or (Secondary to Post-Secondary)
- Other (Specify)

**SECTION E - DOCUMENTATION REQUIRED**

Forward most UP-TO-DATE **information which has NOT previously been sent**

**(Check boxes in appropriate column below)**

<b>Included with referral:</b>	<b>Will be forwarded under separate cover:</b>
<b>Medical:</b>	<b>Medical:</b>
<ul style="list-style-type: none"> <li>■ <b>Eye Report (Ophthalmologist/Optometrist)</b></li> <li>■ Other Medical Information</li> <li>■ Audiological Report (if applicable)</li> </ul> <b>Other</b>	<ul style="list-style-type: none"> <li>■ <b>Eye Report (Ophthalmologist/Optometrist)</b></li> <li>■ Other Medical Information</li> <li>■ Audiological Report (if applicable)</li> </ul> <b>Other</b>
<ul style="list-style-type: none"> <li>■ <b>Parental Consent Form (see attached)</b></li> <li>■ School Progress Report / I.E.P.</li> </ul>	<ul style="list-style-type: none"> <li>■ <b>Parental Consent Form (see attached)</b></li> <li>■ School Progress Report / I.E.P.</li> </ul>
<i>IMPORTANT:</i> Eye Report (if not previously sent or up-to-date report is available), and signed Parental Consent must be provided.	<i>IMPORTANT:</i> Eye Report (if not previously sent or up-to-date report is available), and signed Parental Consent must be provided.

If you have any questions regarding referral, please contact:

Ms. Kerri Readings, Secretary, at the following: Telephone: (519) 759-0730, ext. 219

Fax: Vision Resource Services ONLY - (519) 759-3677

Fax: Other Departments - (519) 759-4741

Please forward completed referral forms (with parental consent) to the following address:

Educational Coordinator  
 Vision Resource Services  
 W. Ross Macdonald School  
 350 Brant Avenue  
 Brantford, ON N3T 3J9

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The W. Ross Macdonald School  
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**CONSENT TO THE FUNCTIONAL ASSESSMENT OF A STUDENT  
WHO IS BLIND OR VISUALLY IMPAIRED  
AND DISCLOSURE, TRANSMITTAL, OR EXAMINATION  
OF A CLINICAL/EDUCATIONAL RECORD UNDER SECTION 35 OF THE ACT**

Please print all information, sign where indicated, and return to above address. Please ensure a signed copy is also forwarded to your child's school.

I (Parent/Guardian) give permission for the Consulting Staff, Vision Resource Services, at the W. Ross Macdonald School (WRNS) to conduct a functional visual educational assessment on my son/daughter, and for the disclosure of pertinent documentation (eye, medical, and school progress reports) to be forwarded by the School to the WRNS in order to proceed with the assessment.

I also request that a written report, completed by staff, be forwarded to my home address.

Name of Student (in full): \_\_\_\_\_

Student's Date of Birth (in full): \_\_\_\_\_

Parent/Guardian (in full)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Home Address (in full):

Street (including R.R. and P.O.) \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Telephone No: \_\_\_\_\_

Work Telephone No's: Mother: \_ ( \_\_\_\_ ) \_\_\_\_\_ Father: \_ ( \_\_\_\_ ) \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Signature of Student (18 years or older):

Dated the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_  
day month year

\*\*This signed consent is only valid for the time up to and including the completion of the resource visit during the school year requested (or if the referral needs to be transferred to the following school year).