

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
Telephone (519) 759-0730
Facsimilie (519) 759-3677



W. Ross Macdonald School **VISION RESOURCE SERVICES**

REFERRAL TO OBTAIN SERVICES FROM VISION RESOURCE SERVICES FOR CHILDREN WHO ARE BLIND OR VISUALLY IMPAIRED (AGES 0 TO 6 YEARS)

Early childhood functional vision assessments by Vision Resource Services are available to children who are blind/visually impaired who: (a) do not have correctable vision, at the present time. (b) reside in the province of Ontario. (c) are 6 years of age or under.

- The attached referral form and parental consent will need to be completed and returned prior to the completion of an assessment.
- The completed referral form and signed parental consent may be faxed or mailed to the address indicated on the attached sheet.
- There is no cost to families/caregivers or other professionals for our services.

IMPORTANT: A letter confirming the date/time of the assessment will be sent after it has been scheduled, with a copy to parents and preschool/daycare personnel (if applicable). If you wish to verify that your request has been received, please contact the Vision Resource Services Secretary at 519-759-0730, ext. 219

NOTE: Assessments and consultations for **Children with Deafblindness** can be requested by contacting W. Ross Macdonald School, **Deafblind Resource Services** at 519-759-0730, ext. 290.

SECTION D - MEDICAL INFORMATION ON CHILD

Other Medical Information, **if applicable** (e.g. CP, Autistic, allergies, etc.):

SECTION E - PERSON FROM MCYS MAKING THIS REFERRAL

Name (Mr./Ms./Dr.):

Position/Title:

Agency Name:

Mailing Address :

Street Number & Name: _____

(if applicable, include P.O. Box / R.R. #)

City: _____ Postal Code: _____

Telephone: _ () _____ Fax: _ () _____

SECTION F - DOCUMENTATION REQUIRED (Only, if currently available)
(check box in appropriate column below)

Included with referral:

- Eye Report (Ophthalmologist/Optomtrist)
- Other Medical Information (if applicable)
- Audiological Report (if applicable)
- Parental Consent Form (see attached)**

Important: Signed parental consent form must be included with completed referral form.

Will be forwarded under separate cover:

- Eye Report (Ophthalmologist/Optomtrist)
- Other Medical Information (if applicable)
- Audiological Report (if applicable)
- Parental Consent Form (see attached)**

Important: Signed parental consent must be included with completed referral form.

If you have any questions regarding referral, please contact the Vision Resource Services Secretary at the following:

Ms. Kerri Readings, Secretary, Vision Resource Services

Telephone: (519) 759-0730, ext. 219

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

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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**CONSENT TO THE FUNCTIONAL VISION ASSESSMENT
OF A CHILD WHO IS BLIND OR VISUALLY IMPAIRED
AND DISCLOSURE , TRANSMITTAL OR EXAMINATION
OF CLINICAL RECORDS UNDER SECTION 35 OF THE ACT**

Please print all information and sign where indicated. Ensure that a witness' signature is obtained before returning this form.

I, _____ of
Parent/Guardian name (in full)

Address of Parent/Guardian (in full)

hereby authorize the staff at the W. Ross Macdonald School, **Vision Resource Services**, to conduct an assessment on my son/daughter. I also hereby authorize the disclosure, transmittal, or examination, of reports/documentation (eye, medical, etc.) to or from:

Name of Agency (in full) (Mr. or Ms.)
Contact Name at Agency (in full)

Located at _____
Agency Address (in full)

() _____ () _____
Telephone Number Agency Fax Number

in respect of _____
Name of Child (in full) Date of Birth (in full)

NOTE: See page 2 to list additional agencies if required

****This consent is valid for a period of 1 year from the date (see below) the signature of the Parent/Guardian was obtained or until such time as the assessment is completed. The Parent/Guardian may revoke this consent in writing at any time.**

Signature of Parent/Guardian Signature of Witness

Dated the _____ day of _____, 2 _____
day month year

Parental Consent - Page 2

PLEASE PRINT ALL INFORMATION BELOW

Name of Child (in full)

Date of Birth (in full)

Parent/Guardian Signature

Date (in full)

5. (Mr. or Ms.) _____

Contact Name (at Agency)

Position (Title)

Name of Agency (in full)

Street Address

City

Postal Code

() _____
Telephone Number

() _____
Fax Number

6. (Mr. or Ms.) _____

Contact Name (at Agency)

Position (Title)

Name of Agency (in full)

Street Address

City

Postal Code

() _____
Telephone Number

() _____
Fax Number

7. (Mr. or Ms.) _____

Contact Name (at Agency)

Position (Title)

Name of Agency (in full)

Street Address

City

Postal Code

() _____
Telephone Number

() _____
Fax Number