Ministry of Education
W. Ross Macdonald School
Vision Resource Services and
Outreach Programs
350 Brant Avenue
Brantford, ON N3T 3J9
Telephone (519) 759-0730
Toll Free: 1-866-618-9092

Ministere de l'Education
W. Ross Macdonald School
Vision Services des Ressources
Programmes de sensibilisation
350 Brant Avenue
Brantford, ON N3T 3J9
Telephone (519) 759-0730
Numéro sans frais: 1-866-618-9092

Ontario

TO: Principal/Superintendent

FROM: Mr. Dan Maggiacomo

DATE: September 1, 2016

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.

Type of Assessment	*Assessment Fee*	***Payment Required***	***Additional Expenses***
Verbal Consultation (no written report)	$50.00 (includes GST)	Upon completion of Resource Services visit (invoice will be forwarded for payment)	All other costs (e.g. mileage, accommodation, meals, etc.)
Written Report	$100.00 (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 ($50 plus expenses) **OR** ☐ Written Report ($100 plus expenses)

Name of Student: Date of Birth:

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

(Print Name: Superintendent/Principal)

Signature **Date**

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Vision Resource Services and Outreach Programs

Assessments can be requested for a student who is visually impaired/blind, or visually impaired/blind with multiple exceptionalities, and is attending or will be attending a publicly funded elementary or secondary school within an Ontario District School Board/Authority. A request can also be submitted for a preschool child with visual impairment.

REFERRAL TO REQUEST AN EDUCATIONAL/FUNCTIONAL VISION ASSESSMENT FOR:

- ☐ **A STUDENT WHO IS BLIND OR VISUALLY IMPAIRED**
- ☐ **A TRANSITION VISIT (Student Transitioning into JK)**
- ☐ **A PRESCHOOL CHILD**
  ***(child must be at least two years of age, not attending school yet, and a potential tactile learner)**

TODAY'S DATE:

- The attached referral form and parental consent must be completed and returned each time a request is being made for a resource visit.
- A referral form can only be accepted from (and completed by) District School Board/School personnel. A request for an assessment cannot be accepted from parents, other agencies/professionals (e.g. social workers, hospital personnel, etc).
- A referral form can only be accepted from (and completed by) the Blind Low Vision Program from Ministry of Children and Youth Services for preschool child.
- The completed referral form and signed parental consent can be emailed or mailed to the following address:

  Vision Resource Services and Outreach Programs
  W. Ross Macdonald School
  350 Brant Ave.
  Brantford, ON N3T3J9

  Email: Kerri.Readings@ontario.ca

- Assessments are provided upon request. Parental consent for a return visit within the same school year is not required.
- Assessments are completed during regular classroom routines within the student's school.
  - Assessment for preschool children is completed at local early years centers/ daycare/preschools however not completed inside the child's residence.
- 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).
- Please contact Blind/Low Vision Resource Services for clarification of resource services offered to students who are blind/visually impaired attending First Nation Community/ Private Schools, or who are Home Schooled.
- To confirm receipt of your referral package or with further questions please contact kerri.readings@ontario.ca

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SECTION "A" INFORMATION ON STUDENT

Name of Child (Last Name):_____ (First Name):_____

Birth Date (yyyy/mm/dd):_____

Ontario Education No: (If applicable)_____

Grade/Program/Level: (If applicable)_____

Eye Condition(s):_____

_____

Acuities: Right eye (OD): _____ Left eye (OS):_____ Both eyes (OU):_____

Medical (indicate other conditions, allergies (be specific), seizures, etc.):_____

_____

Student attends school/pre-school on the following weekdays (please circle):

Mon- ☐ Tues- ☐ Wed- ☐ Thurs- ☐ Fri ☐

Student's program begins at: _____ am / pm AND ends at: _____ am / pm

Nutritional break begins at: _____ am / pm AND ends at: _____ am / pm

SECTION "B" INFORMATION ON SCHOOL AND/OR PRESCHOOL

Name of School/Early Childhood Setting (in full): _____

School/E.C.S.Website:_____

School/E.C.S. (Street Number and Name) _____

_____

City:_____Postal Code: _____

Telephone No.: _____Fax No.:_____

Principal/Supervisor Mr: Ms. First Name:_____Surname:_____

Principal/Supervisor's Email:_____

Teacher(s): Mr. Ms. First Name:_____ Surname:_____

Early Childhood Vision Consultant: (Mr. /Ms.):_____ Email:_____

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SECTION "C" INFORMATION ON DISTRICT SCHOOL BOARD (If applicable)

Name of DSB/Authority (in full): _____

Address of DSB/Authority **OR** Home Base School of the **T**eacher for the Blind/V.I. (in full):

_____

Vision Itinerant Teacher:_____

Vision Itinerant Teacher Email:_____

Telephone No: _____Fax No.: _____

SECTION "D" PERSON REQUESTING REFERRAL

☐ CHECK IF SAME AS PERSON LISTED ABOVE

Name of Person requesting Referral:_____

Email address:_____

DSB or Home School Base: (If applicable)_____

DSB Address (Street Number and Name)_____

P.O. Box/R.R._____City:_____Postal Code:_____

Telephone No: _____Fax No:_____

SECTION "D" DOCUMENT CHECKLIST

*** MUST BE INCLUDED FOR REFERRAL TO BE ACCEPTED**

☐ Eye Report (Ophthalmologist/Optometrist)

☐ Parental Consent Form-original copy (see attached)

Please include items below if applicable.

☐ School Progress Report/IEP (if applicable)

☐ Other Medical Information (if applicable)

☐ Previous CVI Range Assessment (if applicable)

☐ Audiological Report (if applicable)

☐ Other

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SECTION "F" ADAPTIVE EQUIPMENT/PRODUCTS/SOFTWARE

Adaptive Equipment/Products/Software available in the Educational Setting
(If no adaptive equipment/products/software are used by the student, indicate N/A)

	Item	If there are concerns regarding the item, please explain
1	_____	_____
2	_____	_____
3	_____	_____

Adaptive Equipment/Products/Software available in the Home Setting
(If no adaptive equipment/products/software are used by the student, indicate N/A)

	Item	If there are concerns regarding the item, please explain
1	_____	_____
2	_____	_____
3	_____	_____

SECTION "G" REASON(S) FOR REFERRAL

Check Appropriate Box(es):

- ☐ Preschool Assessment
- ☐ Appropriate Adaptive Equipment and/or Software - Eligibility to obtain funding for adaptive equipment (Special Equipment Amount) (Note: Training and set-up is NOT provided)
- ☐ Need for support of a Teacher of the Blind for Instruction in braille literacy
  Pre-braille assessment
- ☐ Recommendations for educational programming
- ☐ Transition Year (Entering School), (Elementary to Secondary) or (Secondary to Post-Secondary / Community Living)
- ☐ CVI Range Assessment
  ***Our mandate has recently changed. We now require medical documentation that indicates diagnosed or suspected vision loss that is cortically/cerebrally based.**
- ☐ Recommended by Consultant (as per previous resource visit)
- ☐ Has the student received an assessment or support from W. Ross Macdonald School, Deafblind Resource Services? If so, please indicated name of consultant

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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 or Early Years Setting.

I (Parent/Guardian) give permission for the Consulting Staff in the Vision, Deaf and Deafblind Resource Services and Outreach Programs, to conduct an Educational/Functional Vision Assessment on my son/daughter, and for the disclosure of pertinent documentation (eye, medical, and school progress reports) to be forwarded by the Board/School to Resource Services–Outreach Programs in order to proceed with the assessment.

Name of Child (in full): _____

Student's Date of Birth (in full): _____

Parent / Guardian (in full) _____

Parents/Guardians: _____

Parents/Guardians: _____

Email Address: _____

Address (in full): _____

Street (including R.R. and P.O.): _____

City: _____ Postal Code: _____

Home Telephone No: _____

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(s) during the school year requested (or if the referral needs to be transferred to the following school year).

☐ **I authorize an Educational Consultant with the Provincial Schools Branch, to video tape/acquire a digital record and/or to photograph my child:**

I understand that this video/digital record may be viewed by the Provincial Admission Committee as part of the information sharing process.

These records may also be used for observation and discussion with Resource Services staff to improve and implement strategies to support your child's educational program.