OKLAHOMA SCHOOL FOR THE BLIND
OUTREACH SERVICES

Place where assessment request will be done: (please check one)

______ OSB ______ Home ______ Home School

EACH QUESTION MUST BE ANSWERED

Reason for referral: ____

____

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Are you requesting placement for the child at OSB? Yes No

Student Information:

Student's First Name ____

Student's Last Name ____

Student's Gender ____

Birth Month/Day/Year (00/00/0000) ________________________________

Age _________ Race/Ethnicity __________ Current Grade Student Attends _________

Parent/Guardian Full Name ____

Street Address ____

City ____ Zip Code ____________________

Primary Phone Numbers – Please enter phone number with area code, and indicate whether Each number is home, work, or cell number.

________________________________ ________________________________

________________________________ ________________________________

E-mail address ____

School Information:

Name of School Student Attends ____

School Street Address ____

School City ______________________________ Zip Code ____________________

Special Education Director or Sooner Start Contact Person & Phone Number

____

Vision Teacher & Phone Number (If applicable)

____

SPECIAL EDUCATION INFORMATION

Primary Disability of Visual Impairment (include physician diagnosis)

____

____

Secondary Disability ____

Does student walk independently? _______ If not, how does student ambulate? (walker, wheelchair, etc…) ____

Verbal ______ Yes _______ No

If nonverbal, please list how the student communicates ____________________________

____

Describe the student's speech-language problem ___________________________________

____

How does the student usually communicate? (gestures, single words, short phrases, sentences)

____

Medical/Health Issues ____

Toilet Trained	Yes	No
GI Tube	Yes	No
Seizure Disorder	Yes	No
Hearing Impairment	Yes	No
Allergies	Yes	No

If yes, please list allergies ___________________________

____

Does student have any Behavioral Issues? ________ If so, what? _______________________

____

List Medications Student is taking ____

____

Other Pertinent Information ____

____

____

____

Only available at student's home or home school:

Functional Vision	**Yes**	**No**
Functional Environment	**Yes**	**No**
Orientation and Mobility	**Yes**	**No**
Visual Consultant for an IEP	**Yes**	**No**

Only available at OSB:

Will the student need Psychological services?	**Yes**	**No**
Intellectual	**Yes**	**No**
Academic	**Yes**	**No**
Developmental	**Yes**	**No**
Occupational Therapy	**Yes**	**No**
Physical Therapy	**Yes**	**No**
Independent Living Skills (ILS)	**Yes**	**No**
ILS – Transitional Living	**Yes**	**No**
Assistive Technology (Visual Specific)	**Yes**	**No**