

# The Smokey Powell Center

GEORGIA ACADEMY FOR THE BLIND



## Referral Checklist for: **Low Vision Evaluation (LVE)**

Student Name: \_\_\_\_\_

DOB (m/d/yyyy): \_\_\_\_\_ Georgia Testing ID (10 digit): \_\_\_\_\_

School District: \_\_\_\_\_ School Name: \_\_\_\_\_

Prior LVE?:  Yes  No Location of Evaluation: \_\_\_\_\_

TVI Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_ Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Student's Chaperon \_\_\_\_\_ Relationship \_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_ Email: \_\_\_\_\_

SpEd Dir. Name: \_\_\_\_\_ Email: \_\_\_\_\_

The following is our **Low Vision Evaluation** list of items needed to complete the referral packet. Please make sure the packet is complete before submitting it.

**The packet will be returned if any items are missing or are out of date.**

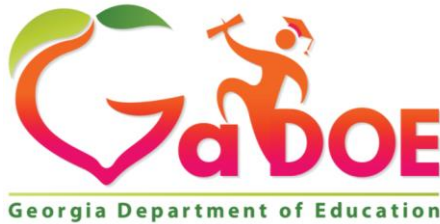
1.  Both the Student and TVI are registered with the GIMC\*
2.  Request for Evaluation (signed by the SpEd Dir. on district letterhead)
3.  Parental Consent for Evaluation (your district form)
4.  Current Eye Report (within one year)
5.  Current IEP
6.  Functional Vision/Learning Media Assessment
7.  Release of Information Form (page 2)
8.  Vision Teacher or LSS designee will attend **virtually** or **in person**. (circle one)

You will be contacted for scheduling when we receive and review the completed packet. We look forward to working with you and your student. Parents are welcome and encouraged to attend low vision evaluations. Please do not hesitate to contact us if you have any questions or concerns.

Sincerely,

**Heather Francis, Admin. Assistant**  
**hfrancis@doe.k12.ga.us**

Smokey Powell Center for Assistive Technology  
2895 Vineville Avenue  
Macon, GA 31204  
Phone: 478-751-6083 x3624 Fax: 866-237-5968



---

***Richard Woods, Georgia's School Superintendent***  
*"Educating Georgia's Future"*

Dr. Kenney Moore Director of State Schools

Dr. Cindy Gibson GAB Superintendent

The Smokey Powell Center for Assistive Technology  
Georgia Academy for the Blind  
Macon, GA 31204

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby permit the Smokey Powell Center to release school records on:

(Name of Student)

To: The Smokey Powell Center Low Vision Optometrist

Reason for Request: Low Vision Evaluation

Records Requested: Eye Report, Functional Vision Assessment, Other reports related to vision

This information may not be transferred to any third parties nor may they have access to the information without the written consent of the parent or eligible student.

I hereby release the administration and the staff of the above agency/institution issuing the information from all liability and all claims of any nature whatsoever pertaining to disclosure of this information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date