Cortical/Cerebral Visual Impairment (CVI) Educational Assessment Intake Form

Student Name:_________________________________________ Date of Birth:________

Parent(s) / Guardian(s):

Name(s):____________________________________________________________________

Address:____________________________________________________________________

____________________________________________________________________________

City:___________________________ State:_________ Zip:_________________

Home Phone:____________________ Cell Phone:___________________________

Email:____________________________________________________________________

How did you hear about Perkins?______________________________________________

Student Information Essential to Assessment (Required):

Ocular Diagnosis:________________________________________________________________

____________________________________________________________________________

Neurological/Cortical Diagnosis:_______________________________________________

____________________________________________________________________________

Other (i.e., autism, genetic disorder, significant birth history, etc.):__________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Please submit the following required background documents:

- Eye doctor report
- Neurology report and MRI report (if available)
- Psychology report (if available)
- Current IEP / IFSP
- Report from Teacher of Students with Visual Impairment (TVI) (e.g., functional vision report, learning media assessment, and/or annual report)
- Video(s) of student

Assessment Payment:

Cost: $1,200.00
Payment Options (please select one):
Private Pay: ______ School Funded: ______

If school funded, please provide contact information below to set up billing. If private pay, you can leave below blank.

School Contact:

Name and Title:__________________________________________________________
Affiliation:______________________________________________________________
Address:________________________________________________________________
City:___________________________ State:_________ Zip:_________________
Phone:_____________________________ Fax:_____________________________
Email:_________________________________________________________________

Please return this form with the requested background documents

Mail: Evaluations Department
      Perkins School for the Blind
      175 North Beacon Street
      Watertown, MA 02472

Or Email: Evaluations@Perkins.org

If you have any questions, please contact us at (617) 972-7573