

Blind-Low Vision (BLV) Teacher/Consultant’s Summary Report

Visual impairment teacher/consultant:

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| Date: |  | School: |  |
| Student name: |  | ID#: |  |
| Date of birth: |  | Grade: |  |

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| **Date** | **Test** | **Results** |
|  | Functional Vision Assessment |  |
|  | Functional Literacy Assessment |  |

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| **Areas of Visual Impairment** | | | | | |
| Eye condition | Visual acuity distance/near | Visual field | Visual cortex (processing) | Oculomotor | Contrast sensitivity |
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| **Other Assessment Date** | |
| Visual skills (fixation, tracking, convergence, scanning, etc.) |  |
| Interview/observations |  |
| General mobility skills |  |

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| **Summary and suggestions** |
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Individual evaluation was conducted in the student’s native language or other communication mode used by the student:

Yes

No

Evaluator’s initials: