LOW VISION EVALUATION (LVE)

PRE-CLINIC SCREENING QUESTIONNAIRE FOR
STUDENTS IN GEORGIA SCHOOLS

(To be completed by school and parent & sent to low vision optometrists prior to the LVE)

Name: 

Date: 

DOB/Age: 

Ocular diagnosis:  

Reported acuities:
Distance: OD OS Intermediate: OD OS
Near: OD OS

Additional medical diagnoses/disabilities:

Date of most recent eye examination: 
Eye doctor:  

(Please attach most recent eye report)

Previous low vision evaluation: ☐ YES ☐ NO If yes, date: 
Person(s) completing this form:

Name of school: ___________________  TVI: ___________________

Grade: ___________________ Placement: □ General education inclusion  □ Special education separate class

Primary language: ___________________  ESOL: □ YES  □ NO

Primary mode of communication: □ Speech  □ ASL  □ SEE  □ Object board  □ Picture symbols

□ Communication device - What kind: ___________________

□ Other - Explain: ___________________

Additional educational problems/disabilities:

Glasses:

Does the student wear his/her glasses? □ YES  □ NO  If yes, what task does the student use his/her glasses to complete (Check all that apply):

□ Near tasks (reading)  □ Intermediate tasks (Computer etc.)  □ Distance Tasks (to see board)

What is the prescription for the current glasses the student is wearing? (Attach script if available).

_________________________
LVE-Pre-Clinic Questionnaire (Continued)

Low Vision Devices/Accommodations currently using: (include working distance & tasks used for)

Optical: 

Electronic: 

Low tech: 

Other: 

Is the student a reader? □ YES □ NO  Is the student a non-reader? □ YES □ NO

If a reader, what is the student’s primary/secondary reading media?

Standard print □ Primary □ Secondary

Point size, font, and working distance: 

Large Print □ Primary □ Secondary

Point size, font, and working distance: 

Braille □ Primary □ Secondary

Auditory □ Primary □ Secondary

Lighting/ Glare Sensitivity
LVE-Pre-Clinic Questionnaire (Continued)

Wears sunglasses to decrease light sensitivity?  □ Outdoors  □ Indoors
Wears a hat or visor to decrease glare?  □ Outdoors  □ Indoors
Uses special or task lighting?  □ YES □ NO
Uses colored overlays?  □ YES □ NO

Visual Fatigue:  Describe visual fatigue if it applies and when it occurs:


VISUAL TASKS

Use the following key to indicate the appropriate statement for each task below:

N/A = Not Applicable
N=Not a problem
M=Mild problem
Y=Major Problem
O= Patient/student desired outcome

READING

☐ Headlines
☐ Large Print (textbooks, general reading & what point size & at what distance)
☐ Standard print (textbooks & general reading)
☐ Newspapers
☐ Magazines
☐ Maps/graphs/line drawings
☐ Photographs & illustrations
☐ Price tags/ labels
☐ Low contrast text/fonts
☐ Cursive writing
LVE-Pre-Clinic Questionnaire (Continued)

- Menus

**WRITING**

- Signing name
- Manuscript writing
- Cursive writing
- Completing forms/worksheets

Preferred writing accommodation(s):  
- Slant board
- Bold line paper
- Bold marker/pencil

**DISTANCE TASKS**

- Recognize gestures
- Recognize nonverbal communication
- Seeing information for group viewing (Auditorium presentations, demonstrations, chalkboard, whiteboard, videos, computer projections, etc.)
- Seeing poster, bulletin board, wall menus, etc.

**COMPUTER**

- Seeing the computer screen
- Finding the cursor on the screen
- Using the mouse

What computer adaptations do you use and does it help?

- Screen magnification software  Does its help?  YES  NO
- Adaptive Screen placement  Does its help?  YES  NO
- Screen reader software  Does its help?  YES  NO
- Glare control (What type?)  Does its help?  YES  NO
- Adaptive keyboard  Does its help?  YES  NO

Working distance from the keyboard:  

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LVE-Pre-Clinic Questionnaire (Continued)

Working distance from the monitor: ___________

**MOBILITY**

- Seeing curbs/stairs
- Traveling in familiar places
- Traveling in unfamiliar places
- Identifying traffic control (Stop signs, traffic lights)
- Reading street signs From what distances?: ___________
- Accommodating to rapid lighting changes
- Safely crossing streets
- Travel at night or in low light
- Night accommodations issues
- Reading bus numbers

**RECREATION & LEISURE**

- Seeing to participate in board games
- Seeing to participate in team games
- Seeing to participate in art activities
- Seeing to participate in your hobbies
- Seeing to read or play music

**OTHER TASKS**

- Telling time:  
  - Digital  
  - Clock face
- Selecting food in a cafeteria
- Seeing food on your plate
- Seeing to accomplish grooming and hygiene tasks
LVE-Pre-Clinic Questionnaire (Continued)

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| ______________________________________ |
| Teacher of the visually impaired Signature |
| ______________________________________   |
| Date                                      |

| ______________________________________ |
| Parent signature                       |
| ______________________________________   |
| Date                                    |

| ______________________________________ |
| Student signature                     |
| ______________________________________   |
| Date                                    |