



Vision/Orientation & Mobility Services

Student Name: _____

Date of Request: _____

Please choose all appropriate services, fill in necessary information and include requested documentation.

To assist Monroe One in fulfilling your request, please indicate the reason for referral and any additional information that will help us provide services: _____

Vision Services

Orientation & Mobility (O & M) Services

Vision Material Prep/Adaptation

O & M Prep/Adaptation

| Type of Service | Frequency (number of hours per week) |
|-----------------|--------------------------------------|
| | |
| | |
| | |
| | |
| | |
| | |

Assessment:

Functional Vision Assessment (FVA)

Orientation & Mobility Assessment (O & M)

CSE Date/Time: _____ OR not scheduled

Documentation Requested (if available):

- **Ophthalmological Report (Required)**
- Previous O & M or FVA Assessments
- IEP/504 (services must match the request)
- Current/Pertinent Reports from other domains
- Cross Contract (if a non-component district)

Send cover sheet, request forms, and requested documentation to itinerant@boces.monroe.edu

OFFICE OF SPECIAL EDUCATION AND STUDENT SERVICES