

IBERVILLE PARISH PUPIL APPRAISAL SERVICES

**Teacher Referral Form
SENSORY SCREENING**

Name: _____ Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

Return This Form To: _____

Please indicate the status of the referral:

Re-Evaluation _____ New Evaluation _____ 504 _____

VISION SCREENING

Acuity _____ Color Blindness _____ Muscle Balance _____

_____ Unable to Accurately Screen Vision

Informal Assessment Indicates _____

Not At Risk _____ At Risk _____ Recheck _____

Referred to Doctor: _____ Yes _____ NO _____

Examiner's Signature *Date*

Comments: _____

HEARING SCREENING

	500	1000	2000	4000	Informal <u>Passed</u>	<u>Failed</u>
RT. Ear	_____	_____	_____	_____	_____	_____
LT. Ear	_____	_____	_____	_____	_____	_____

Not At Risk _____ At Risk _____ Recheck _____

Referred to Doctor: _____ Yes _____ NO _____

Examiner's Signature *Date*

Comments: _____