Southern Worcester County Educational Collaborative
Post Office Box 517

Southbridge, Massachusetts 01550
Tel. (508) 764-8500 ~ Fax. (508) 764-2724
Visit us at: www.swcec.org

Administrative Offices
Dudley, MA 0157

To Whom It May Concern:

My name is Michelle Biron-Bedard and I am a Teacher/Consultant of Students with Visual Impairments for the Southern Worcester County Educational Collaborative (SWCEC). I am a graduate of the Northeast Regional Center for Vision Education program at the University of Massachusetts Boston receiving a certification in Teacher/Consultant of Students with Visual Impairments (TVI) and a Masters in Special Education. I am also a certified Elementary Education Teacher.

A TVI is a special educator trained and certified to provide specialized instruction and services required to meet the unique educational needs of his/her students with visual impairments. Consultation with classroom teachers, staff, specialists and parents is also provided to meet the individual needs of each child.

I am available to offer services that may include direct service, consultation/recommendation, assessment and in-services to both member and non-member districts. Prior to an assessment/observation of a student, it is imperative that a “Vision Referral Form” is completed and returned. This includes submission of the most recent eye report from an Ophthalmologist, and any additional pertinent evaluations.

I look forward to working with you and your students/children. Please do not hesitate to call or email me with any questions, concerns or thoughts you may have regarding your students/children. You may contact me at any time. If I am unavailable to speak with you immediately, I will get back to you as soon as possible. Thank you in advance for your support.

Sincerely,

Michelle Biron-Bedard, M.Ed., TVI
Teacher/Consultant of Students with Visual Impairments
S.W.C.E.C.
508-868-2078
mbedard@swcec.org

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Referral Form

Please complete and *fax* or *mail* to:

Southern Worcester County Educational Collaborative (S.W.C.E.C.)
P.O. Box 517 Southbridge, MA 01550
Attn: Dr. Melissa Manzi, DPT
Phone: 508-764-8500
Fax: 508-764-2724

Please check requested Assessment/Service(s):

____ Adaptive PE
____ Assistive Technology
____ Teacher of the Deaf
____ Learning Media Assessment
____ Music Therapy
____ Physical Therapy
____ Orientation and Mobility
____ Vision (Functional Vision Assessment)
____ Vocational and Life Skills Evaluation
____ Speech Language Pathologist
____ Occupational Therapy
____ Psycho-Educational

Please Print Clearly:

Today's date: ____/_____/_____

District; _____

Referred by: _____

Contact Number: _____ Email: _____

Reason for Referral: _____

_____

_____

Vision (Functional Vision Assessment) Referral Form

Student's Full Name: _____

Student's Date of Birth: _____/_____/_____ Sex: M F Student's Age: Years:_____ Months:_____

Grade:_____ School: _____

Parent/Guardian: _____ Phone #:_____

Teacher: _____ Teacher email: _____

Date Parent/Guardian permission was obtained: _____/_____/_____

Consultation/Assessment approved by: _____
(SIGNATURE OF AUTHORIZED SPECIAL EDUCATION REPRESENTATIVE)

***Please submit the following forms/documentation with the Referral Form. These forms are required BEFORE an assessment can be conducted;**

Therapy:

_____ Current Individual Education Plan (IEP)
_____ Eye Report (Most recent from the Ophthalmologist)
_____ **Relevant** Medical Information/Reports
_____ Pertinent Therapeutic Evaluation Documents
_____ Copy of signed Parent/ Legal Guardian Consent form
_____ List of other services student receives (if applicable)

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