

BABIES COUNT PROJECT

The National Registry for Children with Visual Impairments, Birth to 3 Years

Nebraska Center for the Education of Children Who Are Blind or Visually Impaired

In conjunction with the:
American Printing House for the Blind

CHILD INFORMATION

1. Program Identification: (To be completed by NCECBVI staff)

State Code 2 7 (2-digit)

Agency Code 0 0 1 (3-digit)

Child Code (4-digit)

Please complete this form for each new child with visual impairment, birth to 36 months, referred to your program.

New Registration Initial Submittal Date: M_____ D_____ Y_____

UPDATES: Submit annual updates to NCECBVI. Only complete the survey items where changes have occurred.

1st_____ M_____ D_____ Y_____ No Change

2nd_____ M_____ D_____ Y_____ No Change

3rd_____ M_____ D_____ Y_____ No Change

REMINDER: The survey is to be completed by a service provider and not to be given to a parent/guardian to be completed.

SURVEY FORM SUBMITTAL INFORMATION

Individual completing this survey form should provide **all** information requested:

Date Form Completed: M_____ D_____ Y_____

Person Completing Form_____ Degree_____

Position Within Agency_____ Length With Agency_____

Agency Name_____

Telephone #: _____ Ext. _____

Email_____

IMPORTANT: PLEASE refer to manual for additional information relative to any items on this survey form. If you have questions not answered by referring to the manual, please call 1-800-826-4355.

IMPORTANT: If there is any information that parents/guardians do not feel comfortable sharing, or seems too personal to them, they are not required to answer.

2. Gender: Male Female
3. Ethnicity of child (check **all** that apply):
 Caucasian/White African American/Black Native American
 Asian/Pacific Island Hispanic Other_____
4. Location of primary residence:
 State_____ Postal zip code _____
5. Date of Birth: Month_____ Day_____ Year_____
6. Gestational age at birth: Weeks_____ or Months_____ Full Term
7. Gestational information obtained from: Medical Record Parent Info
8. Birth weight (list in grams or pounds): _____ (grms.) or _____ (lbs.) + _____ (ozs.)
9. Multiple Birth: No Twins Triplets Other_____
10. Date of visual diagnosis or age (in nearest whole month) at the time of diagnosis (date preferred over age):
 Month_____ Day_____ Year_____ or Age_____
11. Referral date to this program: Month_____ Day_____ Year_____
12. Entry date to this program: Month_____ Day_____ Year_____

FAMILY INFORMATION

Information about parents/guardians

13. Biological mother's date of birth: M_____ D_____ Y_____ Unknown
 Age_____

14. Biological father's date of birth: M_____ D_____ Y_____ Unknown
 Age_____

15. Child currently resides primarily with (check **all** persons currently living with child):

Mother	<input type="checkbox"/>	Biological	<input type="checkbox"/>	Foster	<input type="checkbox"/>	Adoptive	<input type="checkbox"/>	Step
Father	<input type="checkbox"/>	Biological	<input type="checkbox"/>	Foster	<input type="checkbox"/>	Adoptive	<input type="checkbox"/>	Step
Grandmother	<input type="checkbox"/>	Maternal	<input type="checkbox"/>	Paternal				
Grandfather	<input type="checkbox"/>	Maternal	<input type="checkbox"/>	Paternal				
Other Adult	<input type="checkbox"/>	Related	<input type="checkbox"/>	Unrelated				
Siblings	<input type="checkbox"/>	_____ (how many)						

16. Primary language spoken in home:

<input type="checkbox"/> English	<input type="checkbox"/> French
<input type="checkbox"/> Spanish	<input type="checkbox"/> Japanese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Hmong
<input type="checkbox"/> Other _____	

17. Level of education completed by parent/guardian:

Mother	Father
<input type="checkbox"/> Highest Grade Completed _____	<input type="checkbox"/> Highest Grade Completed _____
<input type="checkbox"/> High School Diploma or GED	<input type="checkbox"/> High School Diploma or GED
<input type="checkbox"/> Some College	<input type="checkbox"/> Some College
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Associate Degree
<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Some Graduate Courses	<input type="checkbox"/> Some Graduate Courses
<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> Graduate Degree

MEDICAL INFORMATION

18 – 21. Primary visual diagnosis (as determined by medical report); please see manual:

Check only one in column #18 & #20

	Right Eye		Left Eye	
	18. Primary check <u>one</u> only	19. Additional check <u>all</u> that apply	20. Primary check <u>one</u> only	21. Additional check <u>all</u> that apply
Albinism	<input type="checkbox"/>	*	<input type="checkbox"/>	*
Aniridia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anophthalmia	<input type="checkbox"/>	*	<input type="checkbox"/>	*
Aphakia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chorioretinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coloboma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortical Visual Impairment (CVI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed Visual Maturation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemianopsia/Hemianopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leber's Amaurosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microphthalmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nystagmus (sensory & motor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oculomotor Apraxia & Eye Movement Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic Glioma	<input type="checkbox"/>	*	<input type="checkbox"/>	*
Optic Nerve Atrophy or Optic Atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic Nerve Hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Hyperplasia of the Primary Vitreous	<input type="checkbox"/>	*	<input type="checkbox"/>	<input type="checkbox"/>
Peter's Anomaly	<input type="checkbox"/>	*	<input type="checkbox"/>	*
Retinal Detachment (non-ROP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinitis Pigmentosa (RP)	<input type="checkbox"/>	*	<input type="checkbox"/>	*
Retinoblastoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinopathy of Prematurity (ROP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rod/Cone Dystrophies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undetermined (not yet tested)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tested (but not yet diagnosed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Visual Behaviors (check **all** that apply)

- | | |
|---|---|
| <input type="checkbox"/> Eccentric Viewing (head tilt) | <input type="checkbox"/> Photophobic (light sensitive) |
| <input type="checkbox"/> Eye Poking | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Gaze Aversion | <input type="checkbox"/> Responds to objects only if held close |
| <input type="checkbox"/> Head Shaking | <input type="checkbox"/> None |
| <input type="checkbox"/> Inconsistent Visual Performance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Light Gazing (including finger flicking) | |

23. Other Visual Conditions (check **all** that apply):

- | | |
|---|--|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Refractive Errors |
| <input type="checkbox"/> Blepharospasm (excessive blinking) | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Enucleation | <input type="checkbox"/> None |
| <input type="checkbox"/> Field Restrictions | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nystagmus | |
| <input type="checkbox"/> Ptosis (drooping eyelids) | |

24. Does the child have (check **all** that apply):

- | | |
|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> None of the above |

25. Based on medical records, is the child legally blind?

- Yes
 No
 Unknown

Tested Visual Acuity (see manual for codes):

26. Right Eye (O. D.): _____

With Correction	Without Correction	Unknown
-----------------	--------------------	---------

27. Left Eye (O. S.): _____

With Correction	Without Correction	Unknown
-----------------	--------------------	---------

28. Both Eyes (O. U.): _____

With Correction	Without Correction	Unknown
-----------------	--------------------	---------

29. How Was Visual Acuity Determined? (check only if visual acuity listed above)

- Snellen Chart
 Preferential Looking (including Teller Acuity Cards):
 Obtained by Medical Personnel
 Obtained by Service Provider
 Picture Cards with Snellen Equivalents
 Medical Observation
 Other (unknown): _____

Observation of Functional Vision (check **all** that apply):

30. Awareness of:

	Yes	No	Not Tested
Faces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Attention/Fixation on:

	Yes	No	Not Tested
Faces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Following/Tracking of:

	Yes	No	Not Tested
Faces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Etiology of Visual Impairment (indicate exact cause, if known, based on medical report):

<input type="checkbox"/> Anoxia/Asphyxia/Hypoxia	<input type="checkbox"/> Toxins
<input type="checkbox"/> Degenerative Brain or Central Nervous System Disorders	<input type="checkbox"/> Trauma
<input type="checkbox"/> Hereditary/Genetic/Chromosomal Abnormality	<input type="checkbox"/> Shaken Baby Syndrome
<input type="checkbox"/> Prematurity	<input type="checkbox"/> Other _____
Cause of Prematurity, if known _____	<input type="checkbox"/> Tumors
	<input type="checkbox"/> Viral
	<input type="checkbox"/> Other (PLEASE spell correctly) _____
<input type="checkbox"/> Unknown _____	

34. Additional Medical and Health Conditions (check **all** that apply, based on medical report):

<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizure Disorder/Infantile Spasms
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Septo-Optic Dysplasia
<input type="checkbox"/> Deaf or Hearing Impaired	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Technology Dependent (gastrostomy, tracheostomy, oxygen) _____
<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Other Medical or Health Conditions: _____
<input type="checkbox"/> Feeding Problems	
<input type="checkbox"/> Heart Disorder	
<input type="checkbox"/> Orthopedic Impairment	<input type="checkbox"/> None

35. Hearing Test Results: (**Must** check "aided" or "unaided" for first two choices)

<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Aided	<input type="checkbox"/> Unaided
<input type="checkbox"/> Not Within Normal Limits	<input type="checkbox"/> Aided	<input type="checkbox"/> Unaided
<input type="checkbox"/> Tested – inconclusive	<input type="checkbox"/> Not Tested	
<input type="checkbox"/> Unknown		

EARLY INTERVENTION SERVICE INFORMATION

36. Family Referred for Services by (see examples in manual—do not use names):
- Medical Provider (specialty): _____
- Public Agency
- Early Intervention Program
- Family/Friend
- Other (specify): _____
- Unknown
37. Is the child receiving specialized visual impairment (VI) services?
- Yes (please check **all** that apply):
- VI direct services to child and/or family
- VI consult to program or family
- No (if "no", skip to question #40)
38. Where are specialized visual impairment services provided? (check **all** that apply):
- | | |
|--|--|
| <input type="checkbox"/> Specialized VI/EI Program | <input type="checkbox"/> Family Day Care |
| <input type="checkbox"/> Home | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Early Intervention Center | <input type="checkbox"/> Residential Care Facility |
| <input type="checkbox"/> Day Care Center | <input type="checkbox"/> Other _____ |
39. If child is receiving VI services, who provides them? (check **all** that apply):
- | | |
|---|---|
| <input type="checkbox"/> Certified/licensed teacher of students with visual impairments | <input type="checkbox"/> Non-VI certified personnel employed by specialized vision impairment program |
| <input type="checkbox"/> Orientation & Mobility Specialist | <input type="checkbox"/> Early Interventionist |
| <input type="checkbox"/> Deaf/Blind Specialist | <input type="checkbox"/> Other (specify) _____ |
40. Does the child receive related services? (check **all** that apply):
- Developmental Interventionist
- Occupational Therapy
- Physical Therapy
- Speech/Language Pathology Services
- Psychological Services (counseling, evaluation, etc.)
- Other _____
- No
- Unknown

PROGRAM UPDATE INFORMATION

41. Child's Current Status:

- New entry to the program
- Still enrolled in this program
- Moved
- Turned three years of age
- No longer in need of specialized services
- Parent changed early intervention programs
- Parent refused services
- Deceased
- Other _____

TRANSITIONAL INFORMATION

42. Transitional Information: What type of program did child transition into at age of three?

- Not applicable
- Day Care Setting
- Dayschool/Preschool for Students with Visual Impairments Public Private
- Head Start
- Home Services
- Community Preschool Classroom: Public Private
- Pediatric Health Care Facility
- Residential Educational Program
- Special Day Class for Students with Multiple Disabilities
- Special Day Class for Students with Visual Impairments
- Special Day Class for Students with Visual Impairments/Multiple Disabilities
- School for the Blind Preschool Program
- Other _____

43. Will specialized VI preschool services be provided to this child in new setting?

- Yes No Unknown

44. Program Exit Date: M_____ D_____ Y_____

Mail to:

Nebraska Center for the Education of Children Who Are Blind or Visually Impaired
824 10th Avenue PO Box 129
Nebraska City, NE 68410
(800) 826-4355