Children's Traveling Low Vision Clinic Survey

 1. Please tell us about your role in the child's life.

* Parent
* Teacher
* Administrator
* Medical Professional
* Educational Assistant
* Learning Support Teacher
* Learning Coach
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Where and when did you attend the clinic and how was your child/student referred to the low vision clinic?

3. Did you receive sufficient information about the clinic prior to your arrival? If not, what information would you have needed?

4. Was the information provided about your child's eye condition helpful? Please explain.

5. Please rate your satisfaction with each of these clinic components.

Intake:

1. Not at all satisfied
2. Somewhat satisfied
3. Satisfied
4. Very satisfied

Assessment:

1. Not at all satisfied
2. Somewhat satisfied
3. Satisfied
4. Very satisfied

Wrap-up with the team

1. Not at all satisfied
2. Somewhat satisfied
3. Satisfied
4. Very satisfied

Report

1. Not at all satisfied
2. Somewhat satisfied
3. Satisfied
4. Very satisfied

Comments?

6. Is your child using the optical aides provided? What have been the benefits of the optical aides?

7. In your opinion what are the advantages of attending the low vision clinic? Do you have suggestions for improvement?

8. Were the follow-up reports helpful? Why or why not? What follow-up service information or training would be most helpful to you?

9. Would you consider attending a follow-up clinic? Why or why not?

If this was a follow-up clinic, did you find it to be beneficial? Why or why not?

10. Please rate how family-centered you found this service.

1- Not at all family-centered

2 - Somewhat family-centered

3 - Very family-centered