



SOUTH CAROLINA INTERAGENCY DEAF-BLIND PROJECT

EDUCATION REVIEW REFERRAL FORM

The Deaf-Blind project provides technical assistance in the areas of sensory disabilities, communication, and orientation and mobility.

Section I. Student Information

Student's Name: _____

Student's Date of Birth: _____ Student's Age: _____

Parent(s) Name(s): _____

Address: _____

Phone Number: _____ Email: _____

Student's Disability Category: _____ Student's Placement: _____

Visual impairment- cause and severity _____

Hearing impairment – cause and severity _____

Section II. School Information

Referred by: _____

Phone: _____ Email: _____

Teacher's Name: _____

Teacher phone: _____ Email: _____

School: _____

School Phone: _____ School Address: _____

School District: _____ Special Ed Coordinator: _____

District Address: _____

Phone: _____ Email: _____

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| <p>Office use</p> <p>Date of review _____ Directions</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
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List staff persons with whom the student primarily interacts, using their title/position

Section III. Required Additional Information Please check each box. If a Deaf-Blind Census Registration Form is needed, it is available online at www.scsdb.k12.sc.us. Click on the link for Outreach, then the SC Interagency Deaf-Blind Project.

- The student is currently enrolled on the Deaf-Blind Census **OR** a completed Deaf-Blind Census Registration form is attached.
- The parent has been advised that this referral has been made and will be informed of the consultation date.

Section IV. The top three needs/concerns for this consultation in priority order are:

1. _____
2. _____
3. _____

Section V. Student skills and preferences

Student's Favorite Activities

1. _____
2. _____
3. _____

Activities Student Dislikes

1. _____
2. _____
3. _____

What forms of communication does the child use? Check any that apply and * the primary

- ___ Emotional responses (crying, smiling, facial expressions)
- ___ Direct behaviors (tugging on arm, grabbing, pushing away)
- ___ Gestures (actions conveying meaning: waves hello)
- ___ Vocalizations/sounds (approximations of words, whining, squealing)
- ___ Signs (examples _____)
- ___ Speech (words _____)
- ___ Augmented communication devices (switches, pictures, objects)

The child understands when I say _____
because he/she _____

I understand when the child wants _____
because he/she _____

Section VII . The following information would assist in planning this consultation. Please include whatever is available:

- ___ IEP
- ___ Eye Report
- ___ Audiological Report
- ___ Functional Vision Assessment
- ___ Functional Hearing Assessment

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| <p>Please Return Referral Form To: Martha Veto, SCIDBP Project Manager SCSDB Coastal Regional Outreach Center, 300 Rainbow Drive, Suite 103 Florence, SC 29501 Telephone: 843-665-2415, Fax: 843-665-1422, Email: mveto@scsdb.k12.sc.us</p> |
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