PROVINCIAL OUTREACH PROGRAM FOR STUDENTS WITH DEAFBLINDNESS

10300 Seacote Road, Richmond, B.C. V7A 4B2
Phone: (604) 668-7810 Fax: (604) 668-7812 Toll Free: 1-877-294-2934

REFERRAL FORM

STUDENT INFORMATION		
Family Name:	Given Name(s):	
PEN #:		
Birthdate:	Gender:	Referral Date:
Home Address:		
		Ministry Designation:

EDUCATIONAL AUTHORITY		
School District Number/Name:		
School District Office Address:		Postal Code:
School District Administrator:	Email:	Phone:
Name of School:	Classroom Placement:	Phone:
School Address:		Postal Code:
Key Contact:	Email:	Phone:

☐ PARENT / ☐ GUARDIAN INFORMATION (Please Check)		
Name:	Email:	Phone (Home):
Address:	Postal Code:	Phone (Work):

Special Education Services Received from School District (Please Check)

☐ Speech/Language Therapy	☐ Services for Students who are Blind/Visually Impaired
☐ Physio/Occupational Therapy	☐ Services for Students who are Deaf/Hard of Hearing
☐ Psychological/Educational Assessment	☐ Other: (Specify) _____

Has this student been referred to and/or received services from other Provincial Outreach Programs?

☐ SET-BC ☐ Other: (Specify) _____

☐ Provincial Outreach Program for Autism & Pervasive Developmental Disorders

☐ Provincial Inclusion Outreach Program PIOP ☐ Provincial Resource Centre 4 Visually Impaired PRCVI

☐ Provincial Outreach Program for Deaf & Hard of Hearing

SIGNATURES

Parent/Guardian: _____ Key Contact: _____

Principal: _____ District Admin.: _____

STUDENT'S BACKGROUND INFORMATION **Student Name:** _____

Please check and attach the most recent copies (less than two years old) of the following reports:

☐ Ophthalmological/Vision Report ☐ Individual Educational Plan (IEP)

☐ Audiological/Hearing Report ☐ Other relevant medical and/or psych-educational reports

Current Placement - Please describe type of classroom and level of support:

HEARING

Auditory Status - Does the student have any usable hearing? ☐ YES ☐ NO ☐ DON'T KNOW

Does the student wear a hearing aid at school? ☐ YES No. of hours per day _____

* If YES - what hearing equipment is used? _____

VISION

Vision Status - Does the student have any usable vision? ☐ YES ☐ NO ☐ DON'T KNOW

If applicable please describe: _____

Does the student wear glasses? ☐ YES No. of hours per day _____

What other vision aids are used: _____

COMMUNICATION

Communication - Which sense does the student utilize the most for gathering information? _____

Which of the following does the student use to express himself/herself? (Check all that apply)

☐ Vocalization	☐ Gestures	☐ Print
☐ Sign Language	☐ Speech	☐ Braille
☐ Objects	☐ iPad/Augmentative Device	☐ Pictures

Self Care - Please describe: _____

☐ Independent ☐ Semi-Independent ☐ Dependent

Please describe the student's Gross and Fine Motor Skills:

Please describe the student's Social Skills with Adults and Children:

Please describe the student's Academic Level:

Please share any other information that will help us get to know the student: