REFERRAL - KENTUCKY DEAF-BLIND PROJECT

Today's Date _____ Date of Birth _____

Child/Student's Name _____ Social Security # _____

Home Address _____
(Mailing address, city, state, zip – if the mailing address is a P.O. Box also provide the house number/street)

Parent or Guardian's Name: _____

Telephone Number: _____ Email _____

School or Agency Addressing the Child's Educational Needs _____

Address _____

Teacher / Interventionist _____

Type of program (ex: Early Childhood, FMD, Homebound, etc) _____

Etiology _____

Does the child have a vision impairment or challenge? Yes____ No ____ Diagnosis _____
(example: Legally blind)

Physician name / address _____

_____

Does the child have a hearing impairment or challenge? Yes____ No ____ Diagnosis _____
(example: Mild loss)

Physician name / address _____

_____

Other Relevant Information:

_____

_____

Is the parent/guardian aware of contact being made with the Deaf-Blind Project? Yes ____ No ____

Individual Referring Child: _____ Telephone # _____

Title/Role _____ Email _____

To return by mail: Kentucky Deaf-Blind Project, 229 Taylor Education Building, Lexington, KY 40506-0001
To return by email: kim.zeigler@uky.edu or fax to 859-257-1325

(Rev. 9-19)