ARIZONA DEAFBLIND REGISTRY

FOR CHILDREN WITH COMBINED VISION AND HEARING LOSS

REFERRAL FORM for Birth - 3 Year Olds

Main Office -Tucson (520) 770-3268 Satellite Office - Phoenix (602) 771-5237

FOR OFFICIAL USE ONLY:

IDNUM _____ Deafblind Status _____ AZ Deafblind Registry # _____

Date of Referral: _____

CHILD INFORMATION

Name: _____ DOB: _____ Gender: _____

Address: _____

School District Child Resides in: _____ ASDB Region: _____

RACE/ETHNICITY (*check one box only)*

- ☐ 1. American Indian or Alaska Native
- ☐ 2. Asian or Pacific Islander
- ☐ 3. Black or African American (not Hispanic)
- ☐ 4. Hispanic or Latino
- ☐ 5. White (not Hispanic)

CHILD'S RESIDENTIAL/LIVING SETTING

- ☐ 1. Home: Birth/Adoptive Parents
- ☐ 2. Home: Extended Family
- ☐ 3. Home: Foster Parents
- ☐ 4. State Residential Facility
- ☐ 5. Private Residential Facility

PRIMARY LANGUAGE IN THE HOME: _____

- ☐ 6. Group Home (less than 6 residents)
- ☐ 7. Group Home (6 or more residents)
- ☐ 8. Apartment (with non-family person(s))
- ☐ 9. Pediatric Nursing Home
- ☐ 555. Other (Specify) _____

PARENT - GUARDIAN ADDRESS

1st Parent/Guardian Name(s): _____ Phone: _____

Address (note "same" if same as child) _____

IF DIFFERENT from 1st parent:

2nd Parent/Guardian Name(s): _____ Phone: _____

Address: _____

Mom Email: _____ **Dad Email:** _____

Referred by: _____ Agency: _____

Phone: _____ Fax: _____ E-mail: _____

PART C DISABILITY CODE: How the child is reported and counted on Part C Dec. 1 Count

Check one box only *(see p 3 to report additional disabilities)*

- ☐ 1. At-risk (for developmental delays)
- ☐ 2. Developmentally Delayed
- ☐ 3. Mental Retardation
- ☐ 4. Hearing Impaired (includes deafness)
- ☐ 5. Speech or Language Impairment.
- ☐ 8. Orthopedic Impairment
- ☐ 9 Other Health Impairment
- ☐ 10. Specific Learning Disability
- ☐ 11. Deafblindness
- ☐ 12. Multiple Disabilities

PRIMARY IDENTIFIED ETIOLOGY or MAJOR CAUSE OF DEAFBLINDNESS ☐ (Select one from the list below)

Hereditary/Chromosomal Syndromes and Disorders

101 Aicardi syndrome
102 Alport syndrome
103 Alstrom syndrome
104 Apert syndrome (Acrocephalosyndactyly, Type 1)
105 Bardet-Biedl syndrome (Laurence Moon-Biedl)
106 Batten disease
107 CHARGE association
108 Chromosome 18, Ring 18
109 Cockayne syndrome
110 Cogan Syndrome
111 Cornelia de Lange
112 Cri du chat syndrome (Chromosome 5p- syndrome)
113 Crigler-Najjar syndrome
114 Crouzon syndrome (Craniofacial Dysotosis)
115 Dandy Walker syndrome
116 Down syndrome (Trisomy 21 syndrome)
117 Goldenhar syndrome
118 Hand-Schuller-Christian (Histiocytosis X)
119 Hallgren syndrome
120 Herpes-Zoster (or Hunt)
121 Hunter Syndrome (MPS II)
122 Hurler syndrome (MPS I-H)
123 Kearns-Sayre syndrome
124 Klippel-Feil sequence
125 Klippel-Trenaunay-Weber syndrome
126 Kniest Dysplasia
127 Leber congenital amaurosis
128 Leigh Disease
129 Marfan syndrome
130 Marshall syndrome
131 Maroteaux-Lamy syndrome (MPS VI)
132 Moebius syndrome
133 Monosomy 10p
134 Morquio syndrome (MPS IV-B)
135 NF1 - Neurofibromatosis (von Recklinghausen disease)
136 NF2 - Bilateral Acoustic Neurofibromatosis
137 Norrie disease
138 Optico-Cochleo-Dentate Degeneration
139 Pfieffer syndrome
140 Prader-Willi
141 Pierre-Robin syndrome
142 Refsum syndrome
143 Scheie syndrome (MPS I-S)
144 Smith-Lemli-Opitz (SLO) syndrome
145 Stickler syndrome
146 Sturge-Weber syndrome
147 Treacher Collins syndrome
148 Trisomy 13 (Trisomy 13-15, Patau syndrome)
149 Trisomy 18 (Edwards syndrome)
150 Turner syndrome
151 Usher I syndrome
152 Usher II syndrome
153 Usher III syndrome
154 Vogt-Koyanagi-Harada syndrome
155 Waardenburg syndrome
156 Wildervanck syndrome
157 Wolf-Hirschhorn syndrome (Trisomy 4p)
199 Other _____

Pre-Natal/Congenital Complications

201 Congenital Rubella
202 Congenital Syphilis
203 Congenital Toxoplasmosis
204 Cytomegalovirus (CMV)
205 Fetal Alcohol syndrome
206 Hydrocephaly
207 Maternal Drug Use
208 Microcephaly
209 Neonatal Herpes Simplex (HSV)
207 Maternal Drug Use
299 Other _____

Post-Natal/Non-Congenital Complications

301 Asphyxia
302 Direct Trauma to the eye and/or ear
303 Encephalitis
304 Infections
305 Meningitis
306 Severe Head Injury
307 Stroke
308 Tumor
309 Chemically Induced
399 Other _____

Related to Prematurity

401 Complications of Prematurity

Undiagnosed

501 No Determination of Etiology

☐ 6. Visual Impairment (includes blindness)
☐ 7. Emotional Disturbance
☐ 13. Autism
☐ 14. Traumatic Brain Injury

DEGREE OF VISUAL IMPAIRMENT

Documented Vision Loss (Primary Classification of Visual Impairment) Line 8 is purposely left out.

☐ 1. Low Vision (Visual acuity of 20/70 to 20/**200** ***in the better eye with correction.)***
☐ 2. Legally Blind (Visual acuity of 20/200 or less ***or*** field restriction of 20 degrees or less ***in the better eye with correction***.)
☐ 3. Light Perception Only
☐ 4. Totally Blind
☐ 5. Cortical Visual Impairment
☐ 6. Diagnosed Progressive Loss
☐ 7. Further Testing Needed
☐ 9. Documented Functional Vision Loss

DEGREE OF HEARING IMPAIRMENT

Documented Hearing Loss (Primary Classification of Hearing Impairment) Line 8 is purposely left out.

Left Ear

☐ 1. Mild (26-40 dB loss)
☐ 2. Moderate (41-55 dB loss)
☐ 3. Moderately Severe (56-70 dB loss)
☐ 4. Severe (71-90 dB loss)
☐ 5. Profound (91+ dB loss)
☐ 6. Diagnosed Progressive Loss
☐ 7. Further Testing Needed
☐ 9. Documented Functional Hearing Loss

Right Ear

☐ 1. Mild (26-40 dB loss)
☐ 2. Moderate (41-55 dB loss)
☐ 3. Moderately Severe (56-70 dB loss)
☐ 4. Severe (71-90 dB loss)
☐ 5. Profound (91+ dB loss)
☐ 6. Diagnosed Progressive Loss
☐ 7. Further Testing Needed
☐ 9. Documented Functional Hearing Loss

OTHER HANDICAPPING CONDITIONS *(check all that apply)*

☐ Orthopedic/Physical ☐ Cognitive ☐ Behavioral Disorder ☐ Complex Health

☐ Communication, Speech, and/or Language Other (specify): _____

Note: the Deafblind Project will report hearing loss for the more severe ear

Does the child have a central auditory processing disorder? __ NO __ YES

Does the child have a cochlear implant? __ NO __ YES

EDUCATIONAL SETTING FOR INFANTS AND TODDLERS *(check only the section that applies to the child this year)*

☐ 1. Home
☐ 2. Community-based setting
☐ 3. Other setting (specify) _____

EARLY INTERVENTION CONTACTS AND SERVICES *(Fill in only those that apply)*

Primary Service Agency: _____ (ASDB, FBC, DDD, etc.)

ASDB Coordinator: _____
Address: _____
Work Phone: _____ Cell Phone: _____
Fax: _____ E-Mail: _____

FBC Coordinator: _____
Address: _____
Work Phone: _____ Cell Phone: _____
Fax: _____ E-Mail: _____

Parent Advisor: _____
Address: _____
Work Phone: _____ Cell Phone: _____
Fax: _____ E-Mail: _____

DDD Coordinator: _____
Address: _____
Work Phone: _____ Cell Phone: _____
Fax: _____ E-Mail: _____

Does the child have an intervener? __ yes __ no **If yes, intervener's name:** _____

How many hours per week? _____ **Who pays for the intervener?** _____

Please return this form, *with vision, hearing, and other health records* to:

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