ARIZONA DEAFBLIND REGISTRY

FOR CHILDREN WITH COMBINED VISION AND HEARING LOSS
REFERRAL FORM

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

FOR OFFICIAL USE ONLY:
ID Code ____________________ Referral Date ___________________________ AZ Deafblind Registry # ______________

Referred by: ____ Agency: ____
Phone: _____________________ Fax: _____________________ E-mail: ___________________________________

CHILD INFORMATION

Name: ____ DOB: ________________ Gender: _____________
Address: ____

RACE/ETHNICITY (*check one box only*)

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

CHILD'S RESIDENTIAL/LIVING SETTING

- ☐ 0. Home: Parents
- ☐ 1. Home: Extended Family
- ☐ 2. Home: Foster Parents
- ☐ 3. State Residential Facility
- ☐ 4. Private Residential Facility
- ☐ 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) _________________________________

1st Parent/Guardian Name(s): ____ Phone: _________________________
Address: ____

2nd Parent/Guardian Name(s): ____ Phone: _________________________
Address: ____

PRIMARY LANGUAGE IN THE HOME: __________________ **PRIMARY EMAIL** ______________________________________

IDEA INFORMATION - How the Child is Reported and Funded

Funding Category: ☐ IDEA Part C (Birth –2) ☐ C IDEA Part B (3-21) ☐ Not reported under Part B or Part C

AZEIP Category Code For Part C if child under three years old: ***(birth through two years old)***

☐ 1. At Risk ☐ 2. Developmentally Delayed ☐ 888. Not Reported under Part C

Primary Disability Code reported to ADE (AZ Dept. of Ed) for 3 - 22 years olds:

*Check one box only **unless** you are checking BOTH vision and hearing*

- ☐ 0. Not Applicable - Child is under 3 years old
- ☐ 1. Mental Retardation
- ☐ 2. Hearing Impairment (includes deafness)
- ☐ 3. Speech or Language Impairment
- ☐ 4. Visual Impairment (includes blindness)
- ☐ 5. Emotional Disturbance
- ☐ 6. Orthopedic Impairment
- ☐ 7. Other Health Impairment
- ☐ 8. Specific Learning Disability
- ☐ 9. Deaf-blindness (combined, co-existing vision and hearing loss)
- ☐ 10 Multiple Disabilities (please check and circle here if MDSSI)
- ☐ 11. Autism
- ☐ 12. Traumatic Brain Injury
- ☐ 13. Developmentally Delayed (optional category for ages 3-9)
- ☐ 14. Non-Categorical
- ☐ 888. Not Reported under Part B of IDEA

ADE SAIS Number (if over 3 years of age): ________________________________

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

DEGREE OF VISUAL IMPAIRMENT

Documented Vision Loss (Primary Classification of Visual Impairment) _Note_: *Lines 5 and 8 are purposely not used.*

- ☐ 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
- ☐ 6. Diagnosed Progressive Loss
- ☐ 7. Further Testing Needed *(may only be used the first year of referral)*
- ☐ 9. Documented Functional Vision Loss

Does the child have a cortical visual impairment? __ NO __ YES __ UNKNOWN **Corrective lenses?** __ NO __ YES __ UNKNOWN

DEGREE OF HEARING IMPAIRMENT

Documented Hearing Loss (Primary Classification of Hearing Impairment) _Note_: *Line 8 is purposely not used.*

- ☐ 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 *(may only be used the first year of referral)*
- ☐ 9. Documented Functional Hearing Loss

Does the child have a central auditory processing disorder? __ NO __ YES __ UNKNOWN
Does the child have auditory neuropathy? …………………… __ NO __ YES __ UNKNOWN
Does the child have a cochlear implant? …………………… __ NO __ YES __ UNKNOWN
Does the child use assistive listening devices?……………… __ NO __ YES __ UNKNOWN Specify: ______________________________

OTHER IMPAIRMENTS OR CONDITIONS *(check all that apply)*

☐ Physical/Ortho Impairment ☐ Cognitive Impairment ☐ Behavioral Disorder ☐ Complex Health Care Needs
☐ Communication/Speech/Language Impairments
☐ Other: ____

Does the child use any additional assistive technology? __ NO __ YES __ UNKNOWN Specify: ______________________

CURRENT EDUCATIONAL SETTING *(check only the section that applies to the student this year)*

Birth Through Age 2

☐ 1. Home
☐ 2. Community-based settings
☐ 3. Other settings (specify) ______________________________

Ages 3 - 5

☐ 1. Attending a regular early childhood program at least 80% of the time
☐ 2. Attending a regular early childhood program 40% to 79% of the time
☐ 3. Attending a regular early childhood program less than 40% of the time
☐ 4. Attending a separate class
☐ 5. Attending a separate school
☐ 6. Attending a residential facility
☐ 7. Service provider location
☐ 8. Home

Ages 6 -21

☐ 9. Inside the regular class 80% or more of day
☐ 10. Inside the regular class 40% to 79% of day
☐ 11. Inside the regular class less than 40% of day
☐ 12. Separate school
☐ 13. Residential facility
☐ 14. Homebound/Hospital
☐ 15. Correctional facility
☐ 16. Parentally placed in private schools

PARTICIPATION IN STATEWIDE ASSESSMENTS in their *last* statewide assessment

☐ 1. Regular grade-level state assessment
☐ 4. Alternate assessments based on alternate achievement standards
☐ 6. Not yet required (too young)

PROGRAM INFORMATION

If Receiving Early Intervention services: Program Name: ___________________________ Phone: ______________

Name of EI Coordinator: ___________________________ Phone: ______________ E-mail: ______________________

Address: ____

Name of Early Interventionist or PA: ______________________ Phone: ____________ E-mail: ____________________

Address: ____

If Receiving Special Education services (3 – 21 yrs old):

School District of Residence: ____

Special Education Director: ____

Address: ____

Phone: ____________________ Fax: ______________________ E-Mail: ______________________

Name of School Child Attends: ____

Address of School: ____

Phone: ____________________ Fax: ______________________ E-Mail: ______________________

Classroom Teacher: __________________________________ Phone: ______________________

Address: ____

E-mail: __________________________________ Fax: ______________________

IF STUDENT RECEIVES SERVICES FROM A TEACHER OF THE VISUALLY IMPAIRED (VI)

VI Teacher's Name: ______________________________

Phone: ______________ Fax: ______________ E-mail: ______________

Amount of Service Provided (Specify time per day / week / month / quarter)

______ Minutes / Hours (circle one) ……. Per: (check one) ___ Day ___ Week ___ Month ___ Quarter

IF STUDENT RECEIVES SERVICES FROM A TEACHER OF THE HEARING IMPAIRED (HI)

HI Teacher's Name: ______________________________

Phone: ______________ Fax: ______________ E-mail: ______________

Amount of Service Provided (Specify time per day / week / month / quarter)

______ Minutes / Hours (circle one) ……. Per: (check one) ___ Day ___ Week ___ Month ___ Quarter

CHECK IF RECEIVING SERVICES THROUGH ONE OF THE ASDB REGIONAL COOPERATIVES

- ☐ Desert Valley Regional Coop
- ☐ Eastern Highland Regional Coop
- ☐ North Central Regional Coop
- ☐ Southeast Regional Coop
- ☐ Southwest Regional Coop

Does the student have an intervener? __ yes __ no

If yes, what is the intervener's name: ______________ Phone: ______________ Email: ______________

STUDENT COUNT CONTACT: (Who does the Deafblind Project contact regarding the annual Student Count?)

Student Count Contact Person: ______________ Position: ______________

Address: ______________________________

Phone: ______________ Fax: ______________ E-mail: ______________

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

Statewide except Maricopa County:

Megan Mogan
Arizona Deafblind Project
PO Box 85000
Tucson AZ 85754
Ph: (520) 770-3268
Fax: (520) 770-3861
megan.mogan@asdb.az.gov

In the Phoenix area or Maricopa County:

Pat Jung
2051 W Northern Ave.
Suite 200
Phoenix, AZ 85021
Ph: (602) 771-5237
Fax: (602) 544-1744
patrice.jung@asdb.az.gov

Note: Vision records include ophthalmological and functional vision assessments
Hearing records include audiograms, audiological records, and functional hearing assessments

For questions in the Tucson area or around the state, please call (520) 770-3268

For questions in the Phoenix area only, call (602) 771-5237