



ARIZONA DEAFBLIND REGISTRY
FOR CHILDREN WITH COMBINED VISION AND HEARING LOSS
REFERRAL FORM
 Main Office - Tucson (520) 770-3680 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)

- | | |
|--|--|
| <input type="checkbox"/> 1. American Indian or Alaska Native | <input type="checkbox"/> 4. Hispanic |
| <input type="checkbox"/> 2. Asian or Pacific Islander | <input type="checkbox"/> 5. White (not Hispanic) |
| <input type="checkbox"/> 3. Black (not Hispanic) | |

CHILD'S RESIDENTIAL/LIVING SETTING

- | | |
|--|---|
| <input type="checkbox"/> 0. Home: Parents | <input type="checkbox"/> 6. Group Home (less than 6 residents) |
| <input type="checkbox"/> 1. Home: Extended Family | <input type="checkbox"/> 7. Group Home (6 or more residents) |
| <input type="checkbox"/> 2. Home: Foster Parents | <input type="checkbox"/> 8. Apartment (with non-family person(s)) |
| <input type="checkbox"/> 3. State Residential Facility | <input type="checkbox"/> 9. Pediatric Nursing Home |
| <input type="checkbox"/> 4. Private Residential Facility | <input type="checkbox"/> 555. Other (Specify) _____ |

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

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

PRIMARY LANGUAGE IN THE HOME: _____

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

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

ADE SAIS Number (if over 3 yrs of age): _____

PRIMARY IDENTIFIED ETIOLOGY or MAJOR CAUSE OF DEAFBLINDNESS

(Select one from the list below)

Hereditary/Chromosomal Syndromes and Disorders

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

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:

**Cindi Robinson
Arizona Deafblind Project
PO Box 85000
Tucson AZ 85754
Ph: (520) 770-3268
Fax: (520) 770-3861**

In the Phoenix area or Maricopa County:

**Pat Jung
2051 W Northern Ave.
Suite 200
Phoenix, AZ 85021
Ph: (602) 771-5237
Fax: (602) 544-1704**

**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) 770-3680 or 770-3268

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