



**Atlantic Provinces Special Education Authority  
Commission de l'enseignement spécial  
de provinces de l'Atlantique**

5940 South Street, Halifax, Nova Scotia B3H 1S6  
902-424-8500 TTY 902-423-8796

Administration Fax 902-423-8700 Assessment Fax 902-423-8703

**REFERRAL FOR SERVICES**

<b>Child Information:</b>				
Name of Child: <i>(including First, Middle, Last)</i>		D.O.B.		Male <input type="checkbox"/>
		Home Language		Female <input type="checkbox"/>
A Child who is Deaf or Hard of Hearing: <input type="checkbox"/>				
A Child who is Blind or Visually Impaired: <input type="checkbox"/>				
Names of Parents/Guardian:				
Full Address: <i>(including Street, Town)</i>			Postal Code:	
Telephone (home):		Work:		
Cell:		E-mail:		

***Please Note: A copy of the most recent Audiology Report or Eye Report must accompany this signed Referral for Services form.***

***Mail or fax (fax #902-423-8700) the completed form to: APSEA, 5940 South Street  
Halifax, NS B3H 1S6  
Attention: Director***

<b>Additional Information:</b>	
Reason for Referral:	
Additional Disabilities:	

<b>FOR APSEA USE ONLY:</b>	
Director, BVI/DHH:	Date:

<b>School &amp; School District Information:</b> (To be completed for school aged referrals)	
<b>Name of School:</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Principal:</b>	
<b>School Board/District:</b>	
<b>Special Services Coordinator/Supervisor:</b>	
<b>Student's Grade:</b>	

<b>Signatures:</b>			
<b>School/Preschool:</b>		<b>Date:</b>	
<b>Referring Agency:</b>		<b>Date</b>	

<b><i>I hereby grant permission for APSEA staff to complete observations and/or assessments to determine eligibility of my child for APSEA services.</i></b>			
<b>Parent/Guardian:</b>		<b>Date:</b>	

For an electronic version of this form, click on this link: <https://www.apsea.ca/FORMS/Referral for Services.docx>