

Referral for Service Form

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

- Fax to Email the completed form to: 902-424-1369 / Attention: Kyle Hatt (DHH) or email dhh@apsea.ca
- Fax to Email the completed form to: 902-425-6166 / Attention: Wanda Nauss (BVI) or email bvi@apsea.ca

A Child who is Deaf or Hard of Hearing (DHH):

A Child who is Blind or Visually Impaired (BVI):

Name of Child: (Full)			
Preferred Name:		DOB: (YYYY-MM-DD)	
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Non-Binary <input type="checkbox"/>
Address: (Full)			
Home Language:		Phone: (Home)	
Phone: (Cell)		Phone: (Work)	
Email:			
Names of Parent(s)/Guardian(s):			
<p>I hereby grant permission for APSEA staff to:</p> <ul style="list-style-type: none"> • complete observations, interviews, and assessments, • obtain my child's confidential personal information from a medical or educational professional that is relevant to the assessment of my child's eligibility for APSEA services. <p>I understand that this referral gives permission to determine eligibility for APSEA programs and services that provide culturally and linguistically responsive, inclusive, equitable, and accessible educational services and supports to learners who are Deaf or hard of hearing and/or blind or visually impaired.</p>			
Parent(s)/Guardian(s) Signature:			Date:

School & School District Information: (To be completed for school aged referrals)			
Name of School:			
Address: (Full)			
Name of Principal:		Email:	
Phone:		Students Grade:	
School Board/District/Region:			
School/Preschool Signature:			Date:

Child Name: _____

FOR APSEA USE ONLY:

Qualifies	Does not Qualify <input type="checkbox"/>
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DHH Eligibility	BVI Eligibility
<p>Children and youth in New Brunswick and Nova Scotia*, eligible for services, shall be diagnosed by an audiologist within the last 12 months with one of the following:</p> <ul style="list-style-type: none"> • Slight hearing loss or greater in the better ear which is not reversible in a reasonable period of time. <input type="checkbox"/> <p>And</p> <ul style="list-style-type: none"> • Amplification is pursued. <input type="checkbox"/> <p>Or</p> <ul style="list-style-type: none"> • Single-sided deafness. <input type="checkbox"/> <p><u>Supervisor Comments (BVI/DHH):</u></p>	<p>Children and youth in the Atlantic Provinces, eligible for services shall have a diagnosis from a licensed eye specialist within the last 12 months as having one of the following:</p> <ul style="list-style-type: none"> • Visual acuity of 6/21 (20/70) or less, near or distance, in the better eye with best correction. <input type="checkbox"/> • A visual diagnosis or related visual stamina that is not correctable and results in the child's functioning as if their visual acuity is limited to 6/21 (20/70) or less. <input type="checkbox"/> • Visual field of 20 degrees or less, or a diagnosis of hemianopsia or bilateral scotomas. <input type="checkbox"/> • Any progressive eye disease with a prognosis of becoming one of the above in the next few years. <input type="checkbox"/> • Cortical/Cerebral Visual Impairment (CVI). <input type="checkbox"/> • Temporary eye conditions such as post-operative retinal detachment or patching where service for a limited time is required. (at the discretion of the Supervisor of Programs-BVI) <input type="checkbox"/> <p>And</p> <ul style="list-style-type: none"> • Demonstrates limited ability to visually access the full range of program - appropriate media and materials. <input type="checkbox"/>

Education Support Teacher:		
Staff Association(s):		
Comments:		
Supervisor of Programs Signature, BVI/DHH:		Date: