APSEA | Serving Children and Youth Who are Deaf, Hard of Hearing / Blind or Visually Impaired

REFERRAL FOR SERVICE

Child Information: **A Child who is Deaf or Hard of Hearing:** ☐ **A Child who is Blind or Visually Impaired:** ☐			
Name of Child: (Full)			
Preferred Name:			
D.O.B.: YYYY-MM-DD		**Gender:**	Male ☐ Female ☐ Non-Binary ☐
Full Address: **(including Street, Town and Postal Code)**			
Home Language:		**Telephone (Cell):**	
Telephone (Home):		**Telephone (Work):**	
Email:			
Names of Parent(s)/Guardian(s):			

I hereby grant permission for APSEA staff to complete observations and/or assessments to determine eligibility of my child for APSEA services.

Parent(s)/Guardian(s) Signature:________________________________ **Date:**__________________________________

School & School District Information: (To be completed for school aged referrals)			
Name of School:			
Address:			
Telephone:		**Fax:**	
Principal:		**Email:**	
Student Services Coordinator:		**Email:**	
School Board/District:			
Student's Grade:			

School/Preschool Name:____
Signature Print Date

Referring Agency Name:____
Signature Print Date

Student Name: ___________________________

Please Note:

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)
- Fax to Email the completed form to: **902-425-6166** / Attention: Wanda Nauss (BVI)

FOR APSEA USE ONLY: **Qualifies** ☐ **Does not Qualify** ☐

DHH Eligibility	BVI Eligibility
Students, ages birth – 21, eligible for services shall have a diagnosis from a licensed Audiologist within the last 12 months as having at least one of the following:	**Students, ages birth – 21, eligible for services shall have a diagnosis from a licensed eye specialist within the last 12 months as having at least one of the following:**
• Slight hearing loss or greater in the better ear which is not reversible in a reasonable period of time. ☐ And • Amplification is prescribed ☐ Or • Single-sided deafness. ☐	• Visual acuity of 20/70 or less, at near or distance, in the better eye with best correction or, for difficult-to -test children or youth, an estimated acuity and/or visual behavior which is significantly abnormal from what is developmentally age-appropriate. ☐ • Visual field of 20 degrees or less, or a diagnosis of hemianopsia or bilateral scotomas. ☐
Director Comments:	• Congenital or degenerative condition. ☐ • Medical diagnosis of Cortical Visual Impairment (CVI) made by an ophthalmologist, or neurologist. ☐ • Temporary eye conditions such as post-operative retinal detachment or patching where service for a limited time is required (at the discretion of the Provincial Supervisor). ☐

FOR APSEA USE ONLY:

Director Signature, BVI/DHH:		**Date:**	