



www.necdbp.org

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INITIAL CHILD REFERRAL INFORMATION (INITIAL / AT RISK CHILDREN)

Instructions: Please complete this form for a child whose family has not signed a release of information form for the New England Consortium of Deafblind Projects (NEC) due to issues related to deafblind identification (i.e., not an appropriate time to address with the family; testing is not a priority for the family at this time.) *Do not refer a child if the family has clearly stated that they do not wish their child to be registered with NEC.*

Date of Referral: _____

Child's Initials: _____
(first two and last two)

Date of Birth: _____

Referring Person: _____

Teacher Name: _____

School/Program: _____

Grade/Class Room #: _____

Teacher Phone: _____

Teacher Email Address: _____

Etiology or Primary Diagnosis: _____

Vision Status (circle):

1. Low Vision
2. Legally Blind (20/200)
3. Light Perception Only
4. Totally Blind
6. Diagnosed Progressive Vision Loss
7. Further Testing Needed
8. Documented Functional Vision Loss

Hearing Status (circle):

1. Mild (26-40db loss)
2. Moderate (41-55 db Loss)
3. Moderately Severe (56-70 db Loss)
4. Severe (71-90 db Loss)
5. Profound (91+)
6. Diagnosed Progressive Loss
7. Further Testing Needed
9. Documented Functional Hearing Loss

Educational Setting's: choose one
If Birth-2 Early Intervention Setting

1. Home
2. Community based settings
3. Other settings

If Ages 3-5: Educational Setting's #1-8

1. Attending a regular early childhood program at least 80% of the time
2. Attending a regular early childhood program at least 40%-79% of the time
3. Attending a regular early childhood program at less 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

If Ages 6-21: School Age Ed Setting's #9-16

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

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| # | Referral Date | Child 4 Initials | Child DOB | Referred by | School/Program | Teacher Phone | Teacher Email | Etiology | Vision # | Hear # | EI/Ed Set # |
|---|---------------|------------------|-----------|-------------|----------------|---------------|---------------|----------|----------|--------|-------------|
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |
| 7 | | | | | | | | | | | |
| 8 | | | | | | | | | | | |