

NEW ENGLAND CONSORTIUM OF DEAFBLIND PROJECTS

CONNECTICUT DEAFBLIND PROJECT ▲ MAINE DEAFBLIND PROJECT ▲ MASSACHUSETTS DEAFBLIND PROJECT ▲ NEW HAMPSHIRE DEAFBLIND PROJECT

2010 STUDENT REGISTRATION FORM

ATTACH RECENT REPORTS: **HEARING & VISION & EDUCATION PLAN**

STUDENT NAME _____ DATE OF BIRTH _____

STATE ID# _____ AGE _____ GENDER: MALE FEMALE

OFFICE ONLY	APPROVAL _____ <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> AT RISK <input type="checkbox"/> IND. UNDER 3 <input type="checkbox"/> INITIAL CHILD DATE APPROVED _____ STATE CODE _____ ID CODE _____ CHILD # _____ LIAISON _____ <input type="checkbox"/> VISION DATE _____ <input type="checkbox"/> HEARING DATE _____ <input type="checkbox"/> IEP DATE _____ <input type="checkbox"/> RELEASE DATE _____			
FAMILY	<input type="checkbox"/> Guardian 1: _____ <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Other: Address: _____ City: _____ ST: _____ Zip: _____ County: _____ <hr/> <input type="checkbox"/> Guardian 2: _____ <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Other: <input type="checkbox"/> Same Address <input type="checkbox"/> Address is: _____	CONTACT INFO	Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____ Email: _____ <i>Quickest form of contact – please include</i> <hr/> Work Ph: _____ Cell: _____ Email: _____ <i>Quickest form of contact – please include</i>	
	Is parent/guardian aware of this referral? Yes No		Are materials needed in Spanish? Yes No	
CURRENT PROGRAM	School: _____ Address: _____ City: _____ ST: _____ Zip: _____ Contact: _____ Title: _____ Phone: _____ Ext: _____ Email: _____		SPECIAL EDUCATION	SPED Agency: _____ Address: _____ City: _____ ST: _____ Zip: _____ Director: _____ Ph: _____ Case Worker: <input type="checkbox"/> Comm. Blind <input type="checkbox"/> Comm. Deaf <input type="checkbox"/> DMR Name: _____ Title: _____ Phone: _____ Ext: _____
TYPE	<input type="checkbox"/> PRE <input type="checkbox"/> ELEM <input type="checkbox"/> MIDDLE <input type="checkbox"/> HIGH <input type="checkbox"/> HOME			<input type="checkbox"/> NEXT PROGAM:
TEACHER	Name: _____ <input type="checkbox"/> Reg Ed Teacher Email: _____ Ph: _____ School: _____ Address: _____		SPED/TVI	Name: _____ <input type="checkbox"/> SPED Teacher <input type="checkbox"/> Para Email: _____ Ph: _____ School: _____ Address: _____
TVI/COMS/IDDB	Name: _____ <input type="checkbox"/> TVI <input type="checkbox"/> TDB <input type="checkbox"/> O&M <input type="checkbox"/> Speech Email: _____ Ph: _____ School: _____ Address: _____		OT/PT	Name: _____ <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Nurse <input type="checkbox"/> COTA Email: _____ Ph: _____ School: _____ Address: _____
REFER BY	Name: _____ <input type="checkbox"/> _____ Email: _____ Ph: _____ School: _____ Address: _____ City: _____ ST: _____ Zip: _____			

DEAFBLIND CENSUS CODE SHEET 2009

Please complete one form for each individual you are registering. In ALL areas you must choose only ONE item from each category.

8. Primary Identified Etiology (Choose only one)	
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 I)	133 Monosomy 10p
105 Bardet-Biedl syndrome (Laurence Moon-Biedl)	134 Morquio syndrome (MPS IV-B)
106 Batten disease	135 NF1 Neurofibromatosis (von Recklinghausen)
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 (Chromosome 5p)	141 Pierre-Robin syndrome
113 Crigler-Najjar syndrome	142 Refsum syndrome
114 Crouzon syndrome (Craniofacial Dysostosis)	143 Scheie syndrome (MPS I-S)
115 Dandy Walker syndrome	144 Smith-Lemli-Optiz (SLO) syndrome
116 Down syndrome (Trisomy 21 syndrome)	145 Stickler syndrome
117 Goldenhar syndrome	146 Sturge-Weber syndrome
118 Hand-Schuller-Christian (Histiocytosis X)	147 Treacher Collins syndrome
119 Hallgren syndrome	148 Trisomy 13 (Trisomy 13-15, Patau syndrome)
120 Herpes-Zoster (or Hunt)	149 Trisomy 18 (Edwards syndrome)
121 Hunter syndrome (MPS II)	150 Turner syndrome
122 Hurler syndrome (MPS I-H)	151 Usher I syndrome
123 Kearns-Sayre syndrome	152 Usher II syndrome
124 Klippel-Feil sequence	153 Usher III syndrome
125 Klippel-Trenaunay-Weber syndrome	154 Vogt-Koyanagi-Harada syndrome
126 Kniest Dysplasia	155 Waardenburg syndrome
127 Leber congenital amaurosis	156 Wildervanck syndrome
128 Leigh disease	157 Wolf-Hirschhorn syndrome (Trisomy 4p)
129 Marfan syndrome	199 Other: _____
Pre-Natal/ Congenital Complications	Post-Natal/Non-Congenital Complications
201 Congenital Rubella	301 Asphyxia
202 Congenital Syphilis	302 Direct Trauma to eye and/or ear
203 Congenital Toxoplasmosis	303 Encephalitis
204 Cytomegalovirus (CMV)	304 Infections
205 Fetal Alcohol syndrome	305 Meningitis
206 Hydrocephaly	306 Severe Head Injury
207 Maternal Drug Use	307 Stroke
208 Microcephaly	308 Tumors
209 Neonatal Herpes Simplex (HSV)	309 Chemically Induced
299 Other: _____	399 Other: _____
Related to Prematurity	Undiagnosed
401 Complications of Prematurity	501 No determination of etiology

NEW ENGLAND CONSORTIUM OF DEAFBLIND PROJECTS

CONNECTICUT DEAFBLIND PROJECT ▲ MAINE DEAFBLIND PROJECT ▲ MASSACHUSETTS DEAFBLIND PROJECT ▲ NEW HAMPSHIRE DEAFBLIND PROJECT

9. Race/Ethnicity	
1. American Indian or Alaska Native	4. Hispanic
2. Asian or Pacific Islander	5. White (not Hispanic)
3. Black	

10. Documented Vision Loss	
Left Eye _____ Right Eye _____ Date on Vision Report: _____	
1. Low Vision (Visual acuity of 20/70 to 20/200 in better eye with correction)	5. <i>Intentionally left blank</i>
2. Legally Blind (Visual acuity of 20/200 or less or field restriction of 20 degrees or less in the better eye with correction)	6. Diagnosed Progressive Loss
3. Light Perception Only	7. Further Testing Needed (1 year only)
4. Totally Blind	8. <i>Intentionally left blank</i>
	9. Documented Functional Vision Loss

11. Does the individual have CVI?	
Cortical Vision Impairment?	(0) No (1) Yes (2) Unknown

12. Documented Hearing Loss	
Left Ear code _____ Right Ear code _____ Date on Audiology Report: _____	
1. Mild (26-40 dB loss)	5. Profound (91+ dB loss)
2. Moderate (41-55 dB loss)	6. Diagnosed Progressive Hearing Loss
3. Moderately Severe (56-70 dB loss)	7. Further Testing Needed (1 year only)
4. Severe (71-90 dB loss)	9. Documented Functional Hearing Loss

13. Does the individual have Central Auditory Processing Disorder (CAPD)?	
Please include documentation	(0) No (1) Yes (2) Unknown

14. Does the individual have Auditory Neuropathy?	
	(0) No (1) Yes (2) Unknown

15. Does this individual have a Cochlear Implant?	
	(0) No (1) Yes (2) Unknown

16.-21. Other Impairments or Conditions (Circle all that apply)			
Orthopedic/Physical	(0) No	(1) Yes	(2) Unknown
Cognitive	(0) No	(1) Yes	(2) Unknown
Behavioral	(0) No	(1) Yes	(2) Unknown
Complex Health Care Needs	(0) No	(1) Yes	(2) Unknown
Communication, Speech/Language	(0) No	(1) Yes	(2) Unknown
Other (Specify):	(0) No	(1) Yes	(2) Unknown

22. Not used

NEW ENGLAND CONSORTIUM OF DEAFBLIND PROJECTS

CONNECTICUT DEAFBLIND PROJECT ▲ MAINE DEAFBLIND PROJECT ▲ MASSACHUSETTS DEAFBLIND PROJECT ▲ NEW HAMPSHIRE DEAFBLIND PROJECT

23. Part C Category Codes (For Ages Birth – Age 2)	
1. At Risk	888. Not Reported Under Part C
2. Developmentally Delayed	

24. Part B Category Codes (For Ages 3 – 21 Choose One)	
1. Mental Retardation	9. Deafblindness
2. Hearing Impaired (includes deafness)	10. Multi-Disabled
3. Speech or Language Impairment	11. Autism Spectrum Disorder
4. Visual Impairment (includes blindness)	12. Traumatic Brain Injury
5. Emotional Disturbance	13. Developmentally Delayed <i>Age 3 through 9</i>
6. Orthopedic Impairment	14. Non-Categorical
7. Other Health Impairment	888. Not Reported Under Part B of IDEA
8. Specific Learning Disability	

25. Early Intervention (Birth through 2) Settings		
1 Home	2. Community Based Settings	3. Other Settings

26. Educational (3-21) Settings	
ECSE (Age 3–5) Settings	School Aged (Age 6–21) Settings
1 Attending a regular Early Childhood Program at least 80% of the time	9 Inside the regular class 80% or more of the day
2 Attending a regular Early Childhood Program at least 40% - 79% of the time	10 Inside the regular class 40% to 79% of day
3 Attending a regular Early Childhood Program less than 40% of the time	11 Inside the regular class less than 40% of the day
4 Attending a Separate Class	12 Separate School
5 Attending a Separate School	13 Residential Facility
6 Attending a residential facility	14 Homebound/Hospital
7 Service provider location	15 Correctional facilities
8 Home	16 Parentally placed in private schools

27. Does this individual have Participation in Statewide Assessments?
1 Regular grade-level State assessment
2 Regular grade-level State assessment w/accommodations
3 Alternate assessments aligned with grade-level achievement standards
4 Alternate assessments based on alternate achievement standards
5 Modified achievement standards
6 Not yet required

NEW ENGLAND CONSORTIUM OF DEAFBLIND PROJECTS

CONNECTICUT DEAFBLIND PROJECT ▲ MAINE DEAFBLIND PROJECT ▲ MASSACHUSETTS DEAFBLIND PROJECT ▲ NEW HAMPSHIRE DEAFBLIND PROJECT

28. Part C Exiting Status (For Ages Birth – Age 2)

0. In a Part C intervention program	6. Deceased
1. Completion of IFSP prior to reaching maximum age for Part C	7. Moved out of state
2. Eligible for IDEA, Part B	8. Withdrawal by parent (or guardian)
3. Not eligible for Part B, exit with referrals to other programs	9. Attempts to contact the parent and/or child were unsuccessful
4. Not eligible for Part B, exit with no referrals	10. <i>Intentionally left blank</i>
5. Part B eligibility not determined	11. <i>Intentionally left blank</i>

29. Part B Exiting (For Ages 3 – 21)

0. In ECSE or school-aged Special Education Program	6. Moved, Known to be Continuing
1. Transferred to Regular Education	7. <i>Intentionally left blank</i>
2. Graduated with Regular Diploma	8. Dropped Out
3. Received a Certificate	9. <i>Intentionally left blank</i>
4. Reached Maximum Age	10. <i>Intentionally left blank</i>
5. Died	11. <i>Intentionally left blank</i>

30. Deafblind Project Exiting Status

0. Receiving Services from the DB Project.	1. No Longer Receiving Services from the DB Project.
--	--

31. Living Setting (Choose only one)

1. Home: Birth/Adoptive Parents	6. Group Home (less than 6 residents)
2. Home: Extended Family	7. Group Home (6 or more residents)
3. Home: Foster Parents	8. Apartment (with non-family person(s))
4. State Residential Facility	9. Pediatric Nursing Home
5. Private Residential Facility	555. Other (Specify) _____

32. Does this individual use Corrective Lenses?

0. No 1. Yes 2. Unknown

33. Does this individual use Assistive Listening Devices?

0. No 1. Yes 2. Unknown

34. Does this individual have Additional Assistive Technology?

0. No 1. Yes 2. Unknown

PARENT CONTACT AND RECORDS RELEASE

The staff of the New England Consortium has my permission to contact me directly concerning my child who is deafblind and regarding newsletter mailings, parent workshops, regional meetings, and other communications of general interest to parents and/or advocates and to send your child's name to the local vision/hearing agency. AND, I give my permission or the below named person/agency to release information via phone, mail or fax to the New England Consortium regarding my child's vision, hearing and/or education plan. *I understand this information is necessary for registration, will remain confidential, and is requested in order to determine eligibility for deafblind technical assistance/consultation services.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

EXPIRES IS ONE YEAR

CHILD NAME: _____ DOB: _____

CURRENT ADDRESS: _____

EMAIL ADDRESS: _____ HOME PHONE: _____

PLEASE PROVIDE BE GREEN FRIENDLY

WORK PHONE: _____ CELL: _____

I HAVE ATTACHED THE FOLLOWING REPORTS.

- Hearing Report (Audiology) or Functional **Hearing** Assessment (or Dr's Summary)
- Vision Report (Ophthalmology) or Functional **Vision** Assessment (or Dr's Summary)

I DO NOT HAVE HEARING OR VISION REPORTS PLEASE REQUEST RECORDS FROM:

PLEASE SEND RECORDS FOR THE ABOVE NAMED CHILD TO NEC:

HEARING REPORT	NAME:		TITLE:	
	COMPANY:		FLOOR/DEPT:	
	STREET:			
	CITY:		ST:	ZIP:
VISION REPORT	NAME:		TITLE:	
	COMPANY:		FLOOR/DEPT:	
	STREET:			
	CITY:		ST:	ZIP:

PLEASE SEND INFORMATION TO:

NEW ENGLAND CONSORTIUM

Attn: Project Assistant

175 North Beacon St., Watertown, MA 02472

▲ 617.972.7515 Phone ▲ 617.972.7354 Fax ▲

NEC@Perkins.org www.necdbp.org