



REFERRAL FOR SERVICE

Child Information: A Child who is Deaf or Hard of Hearing: <input type="checkbox"/> A Child who is Blind or Visually Impaired: <input type="checkbox"/>			
Name of Child: (Full)			
Preferred Name:			
D.O.B.: YYYY-MM-DD		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/>
Home Language:			
Full Address: (including Street, Town and Postal Code)			
Telephone (Home):		Telephone (Cell):	
E-mail:		Telephone (Work):	
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/Guardian 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:			

Signatures:			
School/Preschool:		Date:	
Referring Agency:		Date:	

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
<p>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:</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 prescribed <input type="checkbox"/> <p>Or</p> <ul style="list-style-type: none"> • Single-sided deafness. <input type="checkbox"/> 	<p>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:</p> <ul style="list-style-type: none"> • 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. <input type="checkbox"/> • Visual field of 20 degrees or less, or a diagnosis of hemianopsia or bilateral scotomas. <input type="checkbox"/> • Congenital or degenerative condition. <input type="checkbox"/> • Medical diagnosis of Cortical Visual Impairment (CVI) made by an ophthalmologist, or neurologist. <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 Provincial Supervisor). <input type="checkbox"/>

FOR APSEA USE ONLY:

Director Signature, BVI/DHH:

Date: