

Connections Project Referral

Please return the completed form to:
Donna Riccobono
Connections Beyond Sight and Sound
1308 Benjamin Building
University of Maryland
College Park, MD 20742

NOTE: To be completed by the student's educational team for any referral made to Connections Project.

Student _____

Date of Birth _____ **Age** _____ **Sex** _____

Residence _____

Telephone _____

Parent(s)/Guardian _____

Address (if different) _____

Phone (H) _____ **(W)** _____

EDUCATIONAL PLACEMENT:

School _____ **Home** _____ **Other** _____

LSS _____ **Grade Level** _____

(If school-based, please complete below):

School Name _____

Address _____

Date _____

Etiology/Relevant Diagnosis _____

Other Disabilities _____

MD Student ID Number _____

Is Student on Deafblind Census? _____

Is There a Transition Plan (ITP)? _____

Spec'l Ed. Administrator _____

Telephone _____

Contact Person _____

Position _____

School/Agency _____

Telephone (W) _____

(H) _____ **(for emergency only)**

LOCAL TEAM SERVING STUDENT

Principal/Administrator _____

Special Education Teacher(s) _____

General Education Teacher(s) _____

Instructional Assistant(s) _____

Others _____

OT _____

PT _____

SLP _____

Vision Consultant _____

Hearing Consultant _____

O&M Instructor _____

Social Worker _____

Guidance Counselor _____

Nurse _____

Psychologist _____

- Copies to:**
- Connections Project Coordinator**
 - School/Agency**
 - Parent(s)**

Request for Technical Assistance

The Connections Project may assist with: IEP/IFSP development and implementation, adapting curriculum and environments, related services/equipment, transition planning, interagency/team collaboration, family support, assessment for Cortical Visual Impairment, etc.

Please indicate specifically what assistance is being requested from the Project.

1. _____

2. _____

3. _____

Signatures (Please sign before returning)

Administrator

Date

Team Representative/Position

Date

FAMILY PERMISSION

I give permission for _____ 's (child's name) educational team to consult with members of the Connections Project regarding his/her educational program for the _____ school year. Connections Project staff have permission to access my child's educational file, to conduct needs and skills assessments, and to share information on my child with each other in order to provide this assistance.

I understand that strict confidentiality will be observed in the use of all information. I also understand that I will not be charged for this consultation.

Date _____

Parent/Guardian Signature _____

ADDITIONAL CONSENTS

I grant permission to the Connections Project to: (please check all that apply)

- take photographs and videotape recordings of my child(ren), myself and my spouse for the purposes of assessment, data collection and information-sharing among my child's educational team members;
- use photographs and videotape recordings of my child(ren), myself and my spouse for the purposes of documentation, dissemination and training. I understand that these photographs or video clips may be published in a brochure, Power Point presentation, or newsletter for the Connections Project.

Date _____

Parent/Guardian Signature _____