Paul V. Sherlock Center
On Disabilities / Rhode Island College

Rhode Island Dual Sensory Impairment Project Referral

Please return the completed form to:

Stefanie Davit, Associate Director

Rhode Island DSI Project
Sherlock Center on Disabilities
Rhode Island College
600 Mt. Pleasant Ave.
Providence, RI 02908

Office: 401-456-4737
Direct Line: 401-456-8752
Fax: 401-456-8150
Email: sdavit@ric.edu

NOTE: The following information is to be completed by the student's educational team/family for any referral made to Rhode Island DSI Project. Please feel free to fax or email the referral to expedite this process. However, a copy of the referral with original signatures must be mailed or presented to the DSI Project on the first visit.

The following documents are required in addition to the referral forms:

- A release form from the referring organization signed by the child's parent or legal guardian.
- A vision evaluation must include information regarding the student's visual acuity (near and distance with correction), field limitation, general visual functioning, nystagmus, ocular motor functioning, date of onset for the vision condition, and etiology.
- A hearing evaluation must include information regarding the student's degree of hearing loss, type of hearing loss, overall hearing functioning, auditory processing loss, date of onset for the hearing condition, etiology, any chronic condition which significantly interferes with the auditory learning mode, current hearing with correction (if necessary).
- An educational report (IEP or IFSP) that documents important information such as effective teaching strategies, student and family preferences, assessment results, present levels of performance in all applicable areas, annual goals, services, and accommodations (such as assistive technology, hearing aids, magnification, and communication).

Student's Name: _____ Date of Referral: _____

Date of Birth: _____ Age: _____ Sex: _____

Etiology/Relevant Diagnosis: _____

Person Completing this Form: _____

Parent/Guardian Contact Information

Parent/Guardian Name(s): _____

Parent/Guardian Email(s): _____

Parent/Guardian Phone(s): _____

For children birth to 3 years old, please complete the following information:

Early Intervention Name: _____

Early Intervention Address: _____

Early Intervention Telephone: _____

Early Intervention Primary Contact: _____

Position/Title: _____

For children 3 years of age or older, please fill out the following information:

Educational Placement: _____

School Name: _____

School Address: _____

School Telephone: _____

School District: _____

Grade Level: _____

Case Manager Name: _____

Case Manager Email: _____

Teacher of Students with Visual Impairments: _____ Email: _____

Other Key Team Members & Email: _____

Student Information

Child's Primary Classification of Vision Loss (check the level that best describes vision loss):

- ☐ Low Vision
- ☐ Legal Blindness
- ☐ Light Perception Only
- ☐ Totally Blind
- ☐ Diagnosed Progressive Loss
- ☐ Other: _____

Child's Primary Classification of Hearing Loss (check the level that best describes hearing loss):

- ☐ Mild Hearing Loss
- ☐ Moderate Hearing Loss
- ☐ Moderate/Severe Hearing Loss
- ☐ Severe Hearing Loss
- ☐ Profound Hearing Loss
- ☐ Diagnosed Progressive Loss
- ☐ Other: _____

Does the child wear glasses? ……..…..☐ yes ☐ no

Does the student have cortical vision impairment (CVI)…….. ☐ yes ☐ no

Does the child wear hearing aids? ……..…….. ☐ yes ☐ no

Does the child use a cochlear implant? ……... ……. ☐ yes ☐ no

Does the child use an FM System? …….... ……... ☐ yes ☐ no

How does the child communicate most effectively? (Examples: oral speech, sign language, picture symbols, representational objects, gestures, informal communication):

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Authorization for Release of Confidential Information

Date: _____	**Name:** _____	**DOB:** _____
Address: _____		**Phone:** _____
Agency/LEA/ School: _____		**Grade:** _____
For the purpose of: _____		

I hereby authorize the RI Dual Sensory Impairment Project to:

Release Records To: ☐ Obtain Records From: ☐ Verbally Exchange Records With: ☐

Agency/School: _____

Address: _____

Phone/Fax: _____

The following confidential records:

- ☐ Academic Records
- ☐ Educational
- ☐ Social History
- ☐ Child Outcomes Summary Forms
- ☐ Medical/Health Records
- ☐ Psychological
- ☐ Clinical/Psychiatric
- ☐ Teacher/Therapist Notes and Observations
- ☐ IEP
- ☐ 504
- ☐ IFSP
- ☐ Speech/Language
- ☐ Meeting Minutes
- ☐ Neuropsychological/Neurodevelopment
- ☐ Eligibility Determination Form
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Audiological
- ☐ Vision Assessments

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

This release is valid for one calendar year. Information released with this authorization will not be given, sold, transferred, or in any way relayed to any other person not specified in the consent form. The consent for release or transfer of information may be withdrawn at any future time in writing to the Paul V. Sherlock Center on Disabilities at Rhode Island College.