OKLAHOMA DEAF-BLIND TECHNICALASSISTANCE PROJECT (OKDBTAP)

SOONER START REFERRAL INFORMATION

Census

Date of Referral: _____ How did you hear about OKDBTAP? _____

Child's Name:_____Birthdate:_____

Parent Name:_____

Address:_____City_____Zip_____

Phone Number (_____)_____Email:_____

If child is not living with parents:

Contact Person:_____

Address:_____City_____Zip_____

Phone Number:_____

➲ **Race/Ethnicity: ____1. American Indian or Alaska Native ____2. Asian or Pacific Islander**

____3. Black (not Hispanic) ____4. Hispanic ____ 5. White (not Hispanic)

➲ **MAJOR CAUSE OF DEAF/BLINDNESS - Indicate the etiology code that best represents the major identified cause of deaf/blindness for the individual, from *page 4* of this form.**

➲ ***ENTER CODE # HERE (from page 4):_____***

DEGREE OF VISION LOSS - Circle one below.

1. Low Vision (visual acuity of 20/70 to 20/200)
2. Legally Blind (visual acuity of 20/200 or less or field restriction of 20 degrees)
3. Light Perception Only
4. Totally Blind
5. (# 5 code has been omitted)
6. Diagnosed Progressive Loss
7. Further Testing Needed
8. (#8 code has been omitted)
9. Documented *Functional Vision Loss*

✓ ***Has a functional vision assessment been completed? _____yes _____no***

✓ ***Does this child have the diagnoses of Cortical Visual Impairment (CVI)?____yes ___no ____unknown***

HEARING LOSS - **Circle one below.**

1. Mild (26-40 dB loss)
2. Moderate (41-55 dB loss)
3. Moderately Severe (56-70 dB loss)
4. Severe (71-90 dB loss)
5. Profound (91+ dB loss)
6. Diagnosed Progressive Loss
7. Further Testing Needed
8. (#8 code has been omitted)
9. Documented *Functional Hearing loss*

✓ ***Has a functional hearing assessment been completed? _____no _____yes***

✓ ***Does the individual have a Central Auditory Processing Disorder? _____ no _____ yes ____unknown***

✓ ***Has this student been diagnosed with Auditory Neuropathy? _____no _____yes _____unknown***

✓ ***Does this child have a cochlear implant? _____no _____yes _____unknown***

ADDITIONAL DISABILITIES - **Circle all that applies.**

1. Orthopedic / Physical Impairments
2. Developmental Delay/Intellectual Disabilities/Cognitive Impairments
3. Behavioral Condition
4. Complex Health Care Needs
5. Communication, Speech and / or Language Impairments
6. Other (Specify) _____

FUNDING CATEGORY

SOONER START

Part C (birth – 2 years old)

1. **At-risk**
2. **Developmentally Delayed**
3. **888. Not reported under Part C**

EARLY INTERVENTION SETTING

1. **Home**
2. **Community Based Settings**
3. **Other setting** _____

SOONER START

Early Intervention Provider: _____

Early Intervention Unit: _____

Address _____ City _____ Zip _____

Phone ( ) _____ EMAIL: _____

PUBLIC SCHOOL **(please complete if the child is transitioning to school)**

School Name _____

Address _____ **City**_____ **Zip**_____

Phone (_____)_____**Fax**_____

Building Principal: _____

Special Education Teacher: _____

Email_____

Return this form to:
University of Oklahoma
Oklahoma Deaf-Blind Project
820 Van Vleet Oval, Rm. 321
Norman, Oklahoma 73019

Other Contact Information:
Phone: (405) 325-0441
Fax: (405) 325-6655
email: okdeafblind@ou.edu

Visit our website: www.ou.edu/okdbp
Friend us on Facebook: Oklahoma Deaf-Blind Technical Assistance Project

PRIMARY IDENTIFIED ETIOLOGY
(Major Cause of Deaf-Blindness)

Etiology: Indicate the *ONE* etiology code from the list below that *best describes* the primary etiology of the individual's primary disability.

Hereditary/Chromosomal Syndromes and Disorders	
101 Aicardi syndrome	130 Marshall syndrome
102 Alport syndrome	131 Maroteaux-Lamy syndrome (MRS VI)
103 Alstrom syndrome	132 Moebius syndrome
104 Apert syndrome (Acrocephalosyndactyly, Type 1)	133 Monosomy 10p
105 Bardet-Biedl syndrome (Laurence Moon-Biedl)	134 Morquio syndrome (MRS IV-B)
106 Batten disease	135 NF1 - Neurofibromatosis (von Recklinghausen disease)
107 CHARGE association	136 NF2 - Bilateral Acoustic Neurofibromatosis
108 Chromosome 18, Ring 18	137 Nome disease
109 Cockayne syndrome	138 Optico-Cochleo-Dentate Degeneration
110 Cogan Syndrome	139 Pfieffer syndrome
111 Cornelia de Lange	140 Prader-Willi
112 Cri du chat syndrome (Chromosome 5p- syndrome)	141 PJerre-Robin syndrome
113 Crigler-Najjar syndrome	142 Refsum syndrome
1 14 Crouzon syndrome (Craniofacial Dysotosis)	143 Scheie syndrome (MRS I-S)
115 Dandy Walker syndrome	144 Smith-Lemli-Opitz (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 (MRS II)	150 Turner syndrome
122 Hurier syndrome (MRS I-H)	151 Usher I syndrome
123 Keams-Sayre syndrome	152 Usher II syndrome
124 Klippel-Feil sequence	153 Usher III syndrome
125 KlippeJ-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-Hirschhom 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 the 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 Pre-maturity	501 No Determination of Etiology

OKLAHOMA DEAF-BLIND
TECHNICAL ASSISTANCE PROJECT

RELEASE OF INFORMATION

Re: _____

Child's Name

COLLECTION OF INFORMATION: Authorization is hereby granted to collect information from SoonerStart Early Intervention and / or the local school district for the purpose of assisting in the development of an educational plan for my child.

The information to be collected shall included: audiology reports, ophthalmology / vision reports, major cause of disability, and educational evaluations and information. These items will be collected on referral forms and school update forms by mail or the telephone.

CERTIFICATION: The undersigned certifies that she/he has read the above and understands the nature and purpose of these authorizations to his/her full satisfaction, and that she/he is duly authorized to consent for the above named child.

Date:_____ Signed:_____

Relationship to the Child:_____

***Please sign two copies* - one will be kept in the child's school file, and the other in a file with the Oklahoma Deaf-Blind Project.**