Connections Project Referral
www.cbss.umd.edu

Please return the completed form to:

Donna Riccobono
University of Maryland
Connections Beyond Sight and Sound
1220 Benjamin Building
College Park, MD 20742
Fax: 301- 405-9995
E-mail: donnaric@umd.edu

NOTE: To be completed by the student's educational team/family for any referral made to Connections Project. Please feel free to fax/e-mail referral to expedite the process. However, a copy of the referral with original signatures will need to be mailed or presented to the Technical Assistant on first visit.

Student_____
Date of Birth_____Age_____Sex___
Residence_____
_____
Telephone_____
Parent(s)/Guardian_____
Address (if different)_____
_____
Phone (H)_____(W)_____
E-mail_____

Date_____
Etiology/Relevant Diagnosis_____
_____
_____
Other Disabilities_____
_____
_____
MD Student ID Number_____
Is Student on Deaf-blind Census?_____
Is There a Transition Plan (ITP)?_____

EDUCATIONAL PLACEMENT:
School_____Home_____Other_____
LSS_____ Grade Level_____
(If school-based, please complete below):
School Name_____
Address_____
_____

Spec'l Ed. Administrator_____
Telephone_____
E-mail _____
Contact Person_____
Position_____
School/Agency_____
Telephone (W)_____
E-mail _____

LOCAL TEAM SERVING STUDENT	**NAME**	**EMAIL**
Principal/Administrator:		
Special Education Teacher(s):		
General Education Teacher(s):		
Vision Consultant:		
Hearing Consultant:		
Instructional Assistant(s):		
O&M Instructor:		
Occupational Therapist:		
Physical Therapist:		
Speech/Language Pathologist:		
Psychologist:		
Social Worker:		
Guidance Counselor:		
Nurse:		
Others (specify role):		

Request for Technical Assistance from CBSS (www.cbss.umd.edu)

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 CBSS Project.

1. _____

_____

2. _____

_____

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, website, PowerPoint presentation, or newsletter for the Connections Project.

Date_____ **Parent/Guardian Signature**_____