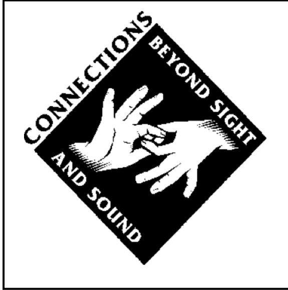
Connections Project Referral
www.cbss.umd.edu

Please return the completed form to:



Donna Riccobono
University of Maryland
Connections Beyond Sight and Sound
3214 Benjamin Building
College Park, MD 20742
Office: 301-405-0482
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___________________:		

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. ____

____

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, power point presentation, or newsletter for the Connections Project.

Date____________________ **Parent/Guardian Signature**_____________________________________