Connections Project Referral
www.cbss.umd.edu

Please return the completed form to:

Donna Riccobono
University of Maryland
Connections Beyond Sight and Sound
3942 Campus Drive, Benjamin Building
Ste. 3214
College Park, MD 20742
Office: 301-405-0482
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_______________________________
____
____
____
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_______________________________________
____

Special Educ. Admin.___________________________
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, Powerpoint presentation, or newsletter for the Connections Project.

Date____________________ **Parent/Guardian Signature____________________________________**