Florida School for the Deaf & the Blind

Parent Infant Program

Referral Information Sheet

Date of Referral: _____ **Person Taking Referral/Position:** _____

Referral Source /Agency: _____ Referral Contact/Position: _____

Phone: _____ Fax: _____ Email: _____

How was this referral received? ☐ In Person ☐ Phone ☐ Fax ☐ Website ☐ Mail ☐ Email

Child's Name: _____ **D.O.B**:_____ Age at time of Referral: _____

Child's Address: _____ City: _____

State: _____ County: _____ Zip: _____ Primary Language: _____

Sensory Concern: ☐ D/HH ☐ B/VI **Sensory Diagnosis**: ☐ Yes ☐ No

Details: _____

Additional Concerns/Diagnosis: _____

Parent/Guardian 1: Resides with Child: ☐ Yes, address above is correct ☐ No, see address below:

Name: _____ Relationship: _____

Preferred Method of Contact: _____ Secondary Contact Info: _____

Address: _____ City: _____ Zip:_____

Languages Spoken in the Home: _____

Parent/Guardian 2: Resides with Child: ☐ Yes, address above is correct ☐ No, see address below:

Name: _____ Relationship: _____

Preferred Method of Contact: _____ Secondary Contact Info: _____

Address: _____ City: _____ Zip:_____

Languages Spoken in the Home: _____

PLEASE FAX TO: PARENT INFANT PROGRAM (904)827-2293

If available, please include most recent: IFSP/IEP and Audiological/Eye Report

OFFICE USE ONLY (Please do not write below this line)

Action Steps Taken/Details:

- ☐ Confirmation of Receipt to Referral Source_____
- ☐ Initial Contact with Guardian (**MUST** document on **Contact Log**): _____
- ☐ Assigned to Parent Advisor: _____
- ☐ Intake/Initial Interview Scheduled: _____
- ☐ Referral to Outside Agency:_____