Ministry of Education
Provincial and Demonstration Schools Branch
W. Ross Macdonald School
350 Brant Avenue
Brantford, ON N3T 3J9
Tel: (519) 759-0730
Fax: (519) 759-4741
Toll Free: (866) 618-9092

Ministère de l'Éducation
Direction des écoles provinciales etd'application
l'École W. Ross Macdonald
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-Functional Assessment-

Deafblind Resource Services and Outreach Programs

The purpose of the assessment is to determine if the learner is functioning primarily as an individual who is deafblind and would benefit from the support of Deafblind Resource Services and Outreach Programs.

The completed referral form, signed parental consent and medical documentation can be emailed to:

Heather.Hickman@ontario.ca

Or mailed to:

Attention: Heather Hickman
Deafblind Resource Services and Outreach Programs
W. Ross Macdonald School
350 Brant Ave.
Brantford, ON
N3T 3J9

Please indicate if this is a request for a Re-Assessment?

STUDENT CONTACT INFORMATION:

Name of Child	*Surname:*		*First Name:*
Gender (Optional)		**Date of Birth (YYYY/MM/DD)**	
Parent(s)/Guardian(s)			
Address:			
Home Phone Number		**Work/Cell Phone Number(s)**	
E-mail Address			

INFORMATION ON SCHOOL AND/OR PRESCHOOL

Name of School / Program	
Address of School / Program	
Phone Number(s)	
Name of School or Program Primary Contact	
E-mail address	
School Board (if applicable)	

ASSESSMENT INFORMATION

Please send/attach copies of the following information.

- Current audiological assessment
- Current ophthalmological assessment
- Current IEP, if applicable
- IPRC documentation (indicating Exceptionality), if applicable
- Etiology, i.e., syndrome (if identified) ____
- Any other information deemed helpful for preparation of assessment, i.e., report of hearingand/or vision by itinerant teacher.
- Other agencies involved, please list:

- Has this child/student been seen previously by Provincial Schools:

    Provincial Schools - Vision Resource

    Provincial Schools- Deaf Outreach

    Out of Province – Deafblind Outreach Programs

Additional relevant information (if necessary)

REFERRED BY:

Name	
Title	
Address	
Phone Numbers	
E-mail Address	

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PARENTAL CONSENT

Provide all information, sign, and return to Deafblind Assessment Coordinator, at the above address.

I, being the parent/guardian of the child, below, give permission for Deafblind Resource Services staff, Provincial Schools Branch, to conduct a functional assessment of my child, and for the disclosure of pertinent documentation (vision, audiological, medical, and school progress reports) to be forwarded by the board/school/agency to Deafblind Resource Services in order to proceed with the assessment.

I authorize the taking of a digital photo/videotape for resource files and for purposes of assessment and review by the Multi-Disciplinary Assessment Team, as well as access to my child's student records (OSR), if applicable.

I also request that a written report be forwarded to my home, my child's school, and other agencies (if applicable).

Name of Child	
Date of Birth (YYYY/MM/DD)	
Parents/Guardians (please print)	

Signature of Parent/Guardian	
Date	