Perkins SCHOOL FOR THE BLIND

175 North Beacon Street
Watertown, MA 02472

COMMUNITY PROGRAMS &
EDUCATIONAL PARTNERSHIPS
Tel 617-972-7332 or 617-972-7444
Fax 617-972-7586

Entered ☐ **Teacher** ☐

BABIES COUNT CODE: _____

INFANT-TODDLER REFERRAL FORM

D.P.H. # _____ **REFERRAL DATE:** _____ **REFERRED BY:** _____

CHILD'S NAME: _____**DOB:**_____**SEX: M** _____**F**_____

PARENTS: _____**CITY / STATE** _____**ZIP**_____

ADDRESS: _____**Region: W**_____**C**_____**NE**_____**SE**_____

Tel (H) _____**Tel (W**_____**Email:**_____

Cell (mom) _____**Cell (dad)** _____ **Primary Language:** _____

EI PROGRAM: _____**Tel (w)** _____**Email:**_____

EI Service Coord: _____**Tel (w)** _____**Cell**_____**Email:**_____

TYPE OF VISUAL IMPAIRMENT:

PRIMARY CAUSE OF IMPAIRMENT:

ADDITIONAL MEDICAL / HEALTH CONDITION:

REASON FOR REFERRAL/CONCERNS:

DOCTOR'S NAME	DISCIPLINE	HOSPITAL
	Ophthalmologist	

OTHER SERVICES:

		FREQUENCY
( )	EDUCATIONAL	_____
( )	PHYSICAL THERAPY	_____
( )	OCCUPATIONAL THERAPY	_____
( )	SPEECH / HEARING THERAPY	_____
( )	NURSING / MEDICAL	_____
( )	PSYCH	_____
( )	SOCIAL WORK	_____
( )	GROUP DAY _____ TIME _____	_____
( )	OTHER _____	_____

MCB NOTIFIED: YES____ **NO**____**WORKER:**_____ **Tel (w)** _____**Cell** _____

IFSP RECEIVED: YES____ **NO**____

OPHTHALMOLOGY REPORT RECEIVED: YES ____ **NO** ____ **NEURO: YES** ____ **NO** ____

SUMMARY OF PARENTAL
Concern needs:

Parent availability: Times _____**Days** _____
Child seen: At home ____**Daycare** _____**other:** _____**Address:**_____

ASSIGNED TO: _____ **DATE ASSIGNED:** _____