DEPARTMENT OF EDUCATION AND SKILLS VISITING TEACHER SERVICE
REFERRAL FORM FOR CHILDREN WHO ARE DEAF/HARD OF HEARING
OR BLIND / VISUALLY IMPAIRED

CHILD'S NAME:		
DATE OF BIRTH:		
PARENTS' NAMES, ADDRESS AND EMAIL		PARENTS' PHONE NO:
REFERRAL MADE BY : (NAME, AGENCY AND CONTACT DETAILS)		
DEGREE OF HEARING LOSS *or* VISUAL ACUITY (best corrected vision) / FIELD OF VISION		
OTHER KNOWN CONDITIONS, IF ANY		
OTHER RELEVANT PERSONNEL		
SCHOOL DETAILS (IF KNOWN)		
Parental consent has been granted for this referral to be made to the visiting teacher service YES ☐ NO ☐		
DATE:		
This form should be returned to the relevant visiting teacher **A recent audiology report (hearing impairment) or ophthalmology report (visual impairment) must accompany this referral.**		