Ontario

Ministry of Education
Provincial Schools Branch
Resource Services – Outreach Programs

Deaf/Hard of Hearing
255 Ontario Street S.
Milton,ON L9T 2M5
Tel: (905) 878-2851

Deaf/Hard of Hearing
350 Dundas Street W.
Belleville, ON K8P 1B2
Tel: (613) 967-2823

Deaf/Hard of Hearing
1090 Highbury Avenue
London, ON N5Y 4V9
Tel: (519) 453-4400

Blind/Low Vision and Deafblind
350 Brant Avenue
Brantford, ON N3T 3J9
Tel: (519) 759-0730
Toll Free: (866) 618-9092
Fax: (519) 759-1293

Resource Services & Outreach Programs - Deafblind

FUNCTIONAL ASSESSMENT

The purpose of the assessment is to determine if the child/student is functioning primarily as an individual with deafblindness and thus be in need of our resource services.

Please complete this form and send as much supporting information as possible to:

Grace Soldaat, Assessment Co-ordinator
Resource Services & Outreach Programs – Deafblind Program
W. Ross Macdonald School
350 Brant Avenue
Brantford, ON N3T 3J9
grace.soldaat@ontario.ca
(519) 759-0730, Ext. 258

Name of Child	__________ Surname __________ First Name
Male / Female	
Date of Birth (year/month/day)	
Parent(s)/Guardian(s)	
Address:	Postal Code:
Home Phone Number	( )
Work/Cell Phone Number(s)	( ) ( )
E-mail Address	

Present School / Program Information

Name of School / Program	
Address of School / Program	Postal Code:
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
- 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 hearing and/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

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 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	
Parents/Guardians (please print)	

Signature of Parent/Guardian	
Date	