



# PUBLIC SCHOOLS OF NORTH CAROLINA

DEPARTMENT OF PUBLIC INSTRUCTION | June St. Clair Atkinson, Ed.D., State Superintendent

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## Early Learning Sensory Support Program/VI Request for Services

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Sex:  Male  Female Race: \_\_\_\_\_ County: \_\_\_\_\_  
 Parents' Names: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Primary Language of Parent: \_\_\_\_\_ Child: \_\_\_\_\_  
 Interpreter needed:  Yes  No Translation needed:  Yes  No

If child is in legal custody of someone other than the person with whom he/she lives, complete the following:

Legally Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

### REFERRAL SOURCE AND CONCERNS:

LEA Making Referral: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Visual Diagnosis: \_\_\_\_\_

### SERVICES REQUESTED (Please check all that apply):

- Functional Vision Assessment Due Date: \_\_\_\_\_
- Orientation & Mobility (O&M) Evaluation Due Date: \_\_\_\_\_
- Vision Services: Frequency and Intensity: \_\_\_\_\_ Location: \_\_\_\_\_
- O&M Services: Frequency and Intensity: \_\_\_\_\_ Location: \_\_\_\_\_

\_\_\_\_\_  
Signature of LEA Representative

\_\_\_\_\_  
Date

After review of current program capacity ELSSP will inform the LEA of it's decision to accept or decline referral within 14 days of its receipt.

Accepted

Declined

\_\_\_\_\_  
Signature of ELSSP Lead Contact

\_\_\_\_\_  
Date

**CURRENT EYE REPORT IS REQUIRED PLEASE ATTACH**  
Fax to 919-733-1873

### OFFICE OF EARLY LEARNING

#### Early Learning Sensory Support Program

Bethany Mayo, Director, Early Learning Sensory Support Program/Visual Impairments | [bethany.mayo@dpi.nc.gov](mailto:bethany.mayo@dpi.nc.gov)  
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