AVITA
COMMUNITY PARTNERS

REFERRAL FORM FOR DEAF SERVICES

PART 1

Name: _____ D.O.B: _____

Address: _____

Video Phone Number: _____ Text/Cell Phone: _____

Parent/Guardian (if applicable): _____Phone Number: _____

What is the individual's hearing status and/or identity?

- ☐ Deaf
- ☐ Hard of Hearing (HOH)
- ☐ Deafblind (Deaf/HOH with vision loss)
- ☐ Late Deafened (Late onset hearing loss as an adult)
- ☐ I don't know

Does the individual prefer to communicate in American Sign Language (ASL)?

☐ Yes ☐ No ☐ I don't know

Reason for Referral: _____

Select Service Needs:

☐ Counseling ☐ Case Management

Note: referral for case management MUST include counseling with a counselor.

Does the individual have insurance?

☐ Yes ☐ No ☐ I don't know

If yes, what type of insurance? _____

PART 2

Name of Individual Making the Referral: _____
Agency/Organization: _____
Relationship to individual: _____
Phone: _____
Fax: _____
E-mail: _____

I understand that a referral is being made to Avita Community Partners on my behalf

Client Signature: _____ Date: _____

***All information is confidential. Please send email to avitadeafservices@avitapartners.org during the week, staff will contact referred individual within 24 hours. ***