

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Referral form for Itinerant Support Service (ISS)** | | | | | | | | | | | | | |
|  | *Scan and email this form together with the supporting documents to iss\_enquiry@sadeaf.org.sg* | | | | | | | | | | | | | |
| 1. **Child's Personal Details** | | | | | | | | | | | | | | |
| Name (as per BC/NRIC) : | | | |  |  |  |  |  |  | |  |  |  |  |
| Gender : \* M / F | | BC / NRIC :  Date of Birth : | | | | Citizenship :  \* SG Citizen / \*\*PR | | | | For PR, indicate the number of immediate family members who are SG Citizen ( ) | | | | |
| Address :  Postal code : ( ) | | | | | | | | | | | | | | |
| 1. **Education Information** | | | | | | | | | | | | | | |
| Name of school : | | | | | | Level : \* N1 /N2 / K1 /K2 | | |  | | Others: | | | |
| 1. **Primary Diagnosis & Assistive Devices** | | | | | | | | | | | | | | |
| Level of Hearing Loss : | | |  |  |  |  |  | Aided | Unaided  (please tick accordingly) | | | | | |
| Type of Aids : Hearing Aids Cochlear Implants BAHA FM / Roger System  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (please tick accordingly) | | | | | | | | | | | | | | |
| Other Medical Condition (if any) : | | | | | |  |  |  |  | |  |  |  |  |
| 1. **Referrer's Details** | | | | | | | | | | | | | | |
| \*(Mr/Mrs/Miss/Mdm/Dr) Full Name : | | | | | |  |  |  |  | |  |  |  |  |
| Name of Organisation : | | | | | | | | |  | |  |  |  |  |
| Department : | |  |  |  |  |  |  |  |  | |  |  |  |  |
| Designation : | |  |  |  |  |  |  |  |  | |  |  |  |  |
| Direct Contact No : | |  |  |  |  |  |  |  |  | |  |  |  |  |
| Email : | |  |  |  |  |  |  |  |  | |  |  |  |  |
| 1. **Parent/Caregiver Information** | | | | | | | | | | | | | | |
| \* (Mr/Mrs/Miss/Mdm/Dr) Full Name : | | | | | |  |  |  |  | |  |  |  |  |
| Address (*if different as above*) : Postal code : ( ) | | | | | | | | | | | | | | |
| Relationship to Child : | | | | | | |  |  |  | |  |  |  |  |
| Home phone : | |  |  |  | HP: |  | | | Email : | | | |  |  |
| 1. **Consent by Parent/Caregiver** | | | | | | | | | | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Parent/Guardian), understand that my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Child) has special educational needs and has been recommended to enrol into the ISS programme. | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  | |  |  |  |  |
| I declare that the information that I have given in this form is true and complete and that I have not withheld any relevant information. I hereby also give consent for the release of this information to relevant professionals and/or agencies, and for SADeaf to contact me, in order to facilitate the application. | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent / Caregiver Signature & date | | | | | |  |  |  |  | |  |  |  |  |
| **Note: Please allow us 3 working days to acknowledge receipt of this referral.** | | | | | | | | | | | |  |  |  |
|  | *\* Please circle appropriately*  *\*\*PRs without one immediate family member (IFM) who is a Singapore Citizen will be considered on a case-by-case basis.* | | | | | | | | | | | | | |
|  | *Supporting Documents required tick accordingly (√ ):* | | | | | | | |  | |  |  |  |  |
|  | Audiogram validated for 1 year | | | | |  |  |  |  | |  |  |  |  |
|  | Doctor's memo on hearing loss | | | | |  |  |  |  | |  |  |  |  |
|  | Other medical documents (if any) | | | | |  |  |  |  | |  |  |  |  |