

|  |  |
| --- | --- |
|  | **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 SystemOthers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (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) |  |  |  |  |  |  |  |  |