REFERRAL INFORMATION

NMSBVI Infant/Toddler Program
801 Stephen Moody St. SE
Albuquerque, New Mexico 87123
(505) 271-3060; (855) 764-6380
Fax: (505) 291-5456

Referral Date: _____

Referral Source: _____

Child's Name: _____ DOB: _____

ICD9 Code: _____ Medicaid #: _____

Place of Birth: _____ Sex: _____ Ethnicity: _____

Parent(s) Name: _____

Address: _____

City: _____ Zip: _____ Phone: _____

Employer: _____ Work Phone: _____

Referral Source Concerns: _____

_____

_____

_____

Vision Diagnosis: _____

Eye Doctor: _____ Date of Last Visit: _____

Other diagnosis or medical information: _____

_____

_____

_____

Primary Care Doctor: _____ Phone: _____

Other agencies involved: _____

Release for Evaluation:
I give the New Mexico School for the Blind and Visually Impaired staff permission to assess the vision and overall development of my child. Information from this assessment will be made available to me.

_____ _____

Parent/Guardian Signature Date

New Mexico School for the Blind and Visually Impaired

Early Childhood Program
801 Stephen Moody St. SE
Albuquerque, NM 87123
Telephone: (505) 271-3060 Fax: (505) 291-5456

Child's Name: _____ Date of Birth: _____

Please list the following specialists for your child.

Eye Specialist Name _____ Address _____ City _____ State ____ Zip _____ Phone _____	**Early Educational Intervention Program** Name _____ Address _____ City _____ State ____ Zip _____ Phone _____
Primary Care Physician Name _____ Address _____ City _____ State ____ Zip _____ Phone _____	**Local Education Agency (School District)** Name _____ Address _____ City _____ State ____ Zip _____ Phone _____
Children's Medical Services Name _____ Address _____ City _____ State ____ Zip _____ Phone _____	_____ Name _____ Address _____ City _____ State ____ Zip _____ Phone _____
_____ Name _____ Address _____ City _____ State ____ Zip _____ Phone _____	_____ Name _____ Address _____ City _____ State ____ Zip _____ Phone _____