Please mail form to:

Sharp Eyed Group
9870 Sugarleaf Place
Fishers, IN 46038

Or Email to:

Empowerment@SharpEyed.org

VP 317-493-0064 if questions

General Referral Information

PERSONAL

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ ☐Voice ☐TTY ☐VideoPhone (VP)

Email: _____ **DOB:** _____ ☐M ☐F

Ethnicity/Race: ☐Caucasian/White ☐African-America ☐Asian ☐Latino ☐Other:

Communication Preference: ☐ASL ☐Oral English ☐PSE ☐SEE ☐Tactile ☐Close Vision

Status: ☐Deaf ☐Hard of Hearing (HH) ☐Late-Deafened ☐DeafBlind

REFERRAL SOURCE

Agency/Organization: _____ **City/State:** _____

Name: _____ ☐Family ☐Provider ☐Self

Phone: _____ **Ext:** _____ ☐Voice ☐VideoPhone (VP)

Email: _____

SUPPORT REQUESTED (can check more than 1 box)

☐Legal	☐Housing	☐Personal Finance	☐Employment
☐Social Security	☐Utilitiy Bills	☐Medicaid/Medicare	☐Health
☐ Hosptial/Medical	☐Immigration	☐Assistive Technology	☐Other:

_____ _____

Referral Agent Signature *Date* *Consumer Signature* *Date*