N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

DEAF BLIND ASSESSMENT

1. NAME: _____

2. ADDRESS: _____ CITY: _____ ZIP CODE _____

3. COUNTY: _____ CODE: _____

4. TELEPHONE NUMBER: (H) _____/___/_____ (W) _____/___/_____ (TTY/V) Fax _____/___/_____

Email _____ Other _____

5. MALE ☐ FEMALE ☐ 6. HIGHEST GRADE COMPLETED: _____

7. LAST SCHOOL ATTENDED: _____

8. DIRECTIONS TO HOME:

9. RACE: White ☐ Black/African American ☐ Native American/Alaska Native ☐ Asian ☐

Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ _____

10. DATE OF BIRTH: _____/___/_____ AGE: _____

11. MARITAL STATUS: Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married ☐

12. NUMBER IN FAMILY: _____

Name:

_____
_____
_____
_____
_____

Family members currently living in home:
Relationship:

_____
_____
_____
_____
_____

13. REFERRAL DATE: _____/___/_____ 14. REFERRAL SOURCE: _____

ADDRESS OF REFERRAL SOURCE _____

15. Are you currently listed on the Register for the Blind? Yes ☐ No ☐

16. If no, date DSB-1010 form submitted _____/___/_____

17. EMPLOYMENT HISTORY

Place of Employment	Job Title	From	To

DEAF BLIND ASSESSMENT

NAME: _____

VISUAL INFORMATION

Retinitis Pigmentosa ☐ Usher Syndrome ☐ Glaucoma ☐ Diabetic Retinopathy ☐
Trauma/Injury ☐ Cataracts ☐ Macular Degeneration ☐ Legally Blind Yes ☐ No ☐

Recommendations/Comments:

HEARING INFORMATION

Age of Onset Left Ear: _____ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Age of Onset Right Ear: _____ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Hearing Aids (brand), if applicable: _____

Left Ear: Has ☐ Needs ☐ Not Applicable ☐
Right Ear: Has ☐ Needs ☐ Not Applicable ☐
Speech Processor Has ☐ Needs ☐ Not Applicable ☐

Hearing Impairment:
Deaf (ASL user, interpreter maybe required) ☐ Hard of Hearing (FM system maybe required) ☐

Recommendations/Comments:

DEAF BLIND ASSESSMENT

NAME: _____

OTHER DISABLING CONDITIONS (Check all that apply)

- ☐ NONE
- ☐ Unknown
- ☐ Alcohol Abuse
- ☐ Arthritis/Rheumatism
- ☐ Autism
- ☐ Amputation
- ☐ Asthma/Allergies
- ☐ Accident
- ☐ Anxiety Disorders
- ☐ Attention Deficit
- ☐ Blood Disorder
- ☐ Cardiac/Circulatory
- ☐ Cystic Fibrosis
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Congenital Condition
- ☐ Digestive
- ☐ Depressive Disorder
- ☐ Drug Abuse
- ☐ Diabetes
- ☐ End Stage Renal
- ☐ Epilepsy
- ☐ Eating Disorder
- ☐ HIV/AIDS
- ☐ Immune Deficiencies not AIDS
- ☐ Learning Disorder
- ☐ MR
- ☐ Multiple Sclerosis
- ☐ Mental Illness
- ☐ Polio
- ☐ Personality Disorder
- ☐ Parkinson's Disease
- ☐ Physical Condition not listed
- ☐ Respiratory
- ☐ Schizophrenia/Psychosis
- ☐ Stroke
- ☐ Spinal Cord Injury
- ☐ Traumatic Brain Injury

MOBILITY (Please check all that apply in each category.)

	Has Skills	Needs	Not Applicable
Travel (white cane)	☐	☐	☐
Support cane	☐	☐	☐
Wheelchair/Scooter	☐	☐	☐
City/County Transportation	☐	☐	☐
Taxi	☐	☐	☐
Guide Dog	☐	☐	☐
City/County Bus	☐	☐	☐

Recommendations/Comments:

DEAF BLIND ASSESSMENT

NAME: _____

COMMUNICATION SECTION

Mode	Has Skills	Needs	Not Applicable
Large Print	☐	☐	☐
Speech Unaided	☐	☐	☐
Speech Aided	☐	☐	☐
Visual Sign Language	☐	☐	☐
Close	☐	☐	☐
Distant	☐	☐	☐
Regular	☐	☐	☐
Tactile Sign Language	☐	☐	☐
Tactile Tracking	☐	☐	☐
Visual Fingerspelling	☐	☐	☐
Tactile Fingerspelling	☐	☐	☐
Print-on Palm	☐	☐	☐
Braille	☐	☐	☐

Recommendations/Comments:

ASSISTIVE LISTENING DEVICES

Device	Has Skills	Needs	Not Applicable
Amplified Phone (ringer)	☐	☐	☐
Amplified Phone (volume)	☐	☐	☐
Pocket Talker	☐	☐	☐
Braille Phone	☐	☐	☐
Telebraille	☐	☐	☐
FM System	☐	☐	☐
TTY	☐	☐	☐

DEAF BLIND ASSESSMENT

NAME: _____

ASSISTIVE LISTENING DEVICES (Continued)

	Has Skills	Needs	Not Applicable
TTY Large Print	☐	☐	☐
TTY w/ LVD	☐	☐	☐
VCO	☐	☐	☐

Recommendations/Comments:

ASSISTIVE ALERTING DEVICES

Device	Has Skills	Needs	Not Applicable
Smoke Detector	☐	☐	☐
Flashing Light Alert	☐	☐	☐
Vibrating Alarm Clock	☐	☐	☐
Amplified Alarm Clock	☐	☐	☐
Phone Signaler	☐	☐	☐
Wired Doorbell	☐	☐	☐
Portable Doorbell	☐	☐	☐
Fan-blower Alert	☐	☐	☐
Vibra-call	☐	☐	☐

Recommendations/Comments:

DEAF BLIND ASSESSMENT

NAME: _____

RESIDENCE

Lives independently at home ☐ Lives in a small-group home ☐
Lives in a facility ☐ (describe) _____
Other living arrangement ☐ (describe) _____

Accommodations in Home:	Has Skills	Needs	Not Applicable
Wheelchair Ramps	☐	☐	☐
Bathroom Safety Rails	☐	☐	☐
Safety Rails	☐	☐	☐

Recommendations/Comments:

INDEPENDENT LIVING SKILLS

	Has Skills	Needs	Not Applicable
Grooming	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐
Money Management	☐	☐	☐
TV with volume	☐	☐	☐
TV w/ regular captions (CCTV)	☐	☐	☐
TV with Braille captions	☐	☐	☐
Radio with amplified headset	☐	☐	☐
Radio Reading Service	☐	☐	☐
Talking books	☐	☐	☐
Library for the Blind	☐	☐	☐

Recommendations/Comments:

DEAF BLIND ASSESSMENT

NAME: _____

RESOURCES (check all that apply)

	N/A	Unaware	Informed	Referred	Serviced
Division of Services for D/HOH	☐	☐	☐	☐	☐
Social Worker for the Blind (County)	☐	☐	☐	☐	☐
(DSB) Rehabilitation Services	☐	☐	☐	☐	☐
(VR) Rehabilitation Services	☐	☐	☐	☐	☐
DEIE Programs	☐	☐	☐	☐	☐
Camp Dogwood Deaf-Blind Weekends	☐	☐	☐	☐	☐
Local Support Groups	☐	☐	☐	☐	☐
Telephone Equipment Distribution Program	☐	☐	☐	☐	☐
Local Communication Center	☐	☐	☐	☐	☐
(DSB) Independent Living	☐	☐	☐	☐	☐
(VR) Independent Living	☐	☐	☐	☐	☐
Mental Health Services	☐	☐	☐	☐	☐
N. C. Deaf-Blind Association	☐	☐	☐	☐	☐
N. C. Council for the Blind	☐	☐	☐	☐	☐
Self Help for Hard of Hearing (SHHH)	☐	☐	☐	☐	☐
Local Deaf Club	☐	☐	☐	☐	☐
Easter Seal	☐	☐	☐	☐	☐
Federation for the Blind	☐	☐	☐	☐	☐
Lions Foundation Hearing Aid Program	☐	☐	☐	☐	☐

DEAF BLIND ASSESSMENT

NAME: _____

RECOMMENDATIONS/ADDITIONAL NOTES:

I certify that the information on this form is true and agree to receive services from the Deaf-Blind Program administered by the North Carolina Division of Services for the Blind (DSB). I further agree to be counted on the State and National Registry of individuals with hearing and vision loss.

Signature _____ Date _____

Completed by _____ Date _____