

Dear Educator:

The Cooperative Association for Special Education (CASE) is pleased to provide you the attached Low Incidence Referral Packet for hearing, and vision itinerant services. All enclosed forms may be duplicated.

Referrals to Low Incidence Itinerant Services, as part of the full and comprehensive case study, for individuals 3 to 22 years, are made by the multi-disciplinary team when the student is being considered for special education services or at any time when an educational disability in the areas of hearing, or vision is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please email or mail a copy of the completed itinerant referral to:

Tricia Sharkey  
CASE Itinerant Services  
290 Town Center Lane  
Glendale Heights, IL 60139  
tsharkey@casedupage.com

When all referral materials are received, the student will be evaluated by a member of the CASE Itinerant Services diagnostic staff in the low incidence domain requested. There will be a diagnostic evaluation charge for each individual evaluation. The school district will receive a copy of the functional report and be billed for the service upon completion of the evaluation.

CASE staff members are available if needed to in-service school districts regarding the use of these forms. If you have any questions regarding the enclosed information or children considered for evaluation, please feel free to contact us.

Respectfully,

Tricia Sharkey  
CASE Itinerant Services Administrator

**Please utilize the following pages when making a referral for hearing services**

### **Statement of Services for Children with Hearing Impairment**

Hearing itinerant services may be requested to address (but not limited to) the following:

1. Sensorineural loss of hearing in conjunction with described academic difficulties and/or speech and language delays.
2. Audiological monitoring of a progressive hearing impairment in conjunction with an audiologist.
3. Longstanding conductive or fluctuating hearing impairment which has not responded to medical intervention.
4. Longstanding medically documented fluctuating hearing loss.
5. Unilateral hearing impairment which is contributing to a reduction in educational progress in the classroom.
6. A recommendation for monitoring of a hearing impairment by a physician or an audiologist (including ABR results).
7. Preschool or multi-needs children or who are unable to complete a school screening test but who may present a combination of the following symptoms:
  - a. Lack of attention or concentration.
  - b. Significant speech and language delays, unintelligible speech.
  - c. Failure to understand when not facing the speaker.
  - d. Inability to comprehend verbal instructions.

## REFERRAL FOR HEARING SERVICES

Student Name \_\_\_\_\_ Gender: M F Date of Birth \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Parent(s)/Guardian(s): \_\_\_\_\_ Work/Cell Phone (\_\_\_\_) \_\_\_\_\_  
Parent(s)/Guardians(s) Email: \_\_\_\_\_  
Resident District: \_\_\_\_\_ Resident School: \_\_\_\_\_  
Attending District: \_\_\_\_\_ Attending School: \_\_\_\_\_ School Phone: (\_\_\_\_) \_\_\_\_\_  
Attends: AM PM Full Day School Nurse: \_\_\_\_\_ Nurse Email: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Teacher Email: \_\_\_\_\_

### Functional Hearing Assessment

*Upon receipt of the referral a Functional Hearing Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.*

Please note: Audiological evaluations are completed through a third party. If you wish to request an audiological evaluation, contact the CASE office for assistance in coordinating an audiological evaluation: (630) 629-2600.

### Documentation REQUIRED with this packet:




Audiogram AND  
Audiological Report

Appropriate administrative  
signatures (see below)

Educational screening  
form completed by  
teachers (see attached)

### If proceeding, documentation required prior to scheduling the evaluation:

- ✓ Domain sheet and parent/guardian consent for evaluation
- NOTE: Hearing itinerant teachers/evaluators do not typically need to be in attendance at the domain meeting.
- NOTE: Domain needs to be completed as follows (Embrace screenshot for reference):

Hearing/Vision <span>Import Hearing/Vision</span>		
Auditory/visual problems that would interfere with testing or education performance. Dates and results of last hearing/visual test.		
Existing Information About the Child	Additional Evaluation Data Needed	Sources From Which Data Will Be Obtained
 [Description of hearing loss as documented by audiological report]	 [must include]: Functional Hearing Assessment	 [must include]: CASE Itinerant Services

- ✓ Educational information (i.e. IEP, #504 plan)
- ✓ Class schedule (Jr. High and High School)

Referring Person: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Person Email: \_\_\_\_\_

District Special Education Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator Email: \_\_\_\_\_

## Educational Screening Form for Students with Suspected or Confirmed Hearing Concerns

*(must be attached to "Referral for Hearing Services")*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Current related services: \_\_\_\_\_

Describe any concerns about this student's ability to hear in the classroom:

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Do you feel that this child's ability to hear is impacting academic performance? If so, how and how significantly?

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Please describe where the student is seated in the classroom:

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Does this student use an amplification device?  
E.g., hearing aids, cochlear implant, BAHA, etc.

☐ YES ☐ NO (if Yes) Type: \_\_\_\_\_

If so, is the amplification device worn consistently?

☐ YES ☐ NO

Does this student have difficulty:

listening in the presence of noise?

☐ YES ☐ NO

following verbal directions?

☐ YES ☐ NO

discriminating similar-sounding words?

☐ YES ☐ NO

starting a task without looking at peers?

☐ YES ☐ NO

responding appropriately to spoken language?

☐ YES ☐ NO

Does the student frequently need additional repetition or clarification, beyond peers?

☐ YES ☐ NO

Is this student easily frustrated?

☐ YES ☐ NO

Is this student's attention span shorter than his/her peers?

☐ YES ☐ NO

Is this student more distractible than others in the classroom?

☐ YES ☐ NO

This student's overall academic skills?

☐ HIGH ☐ AVERAGE ☐ LOW

Do you feel this student's achievement reflects his/her potential? \_\_\_\_\_

For modified/assisted programming students, please describe performance, functioning, and school environment:

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Additional comments and information: \_\_\_\_\_

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Signed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_