CASE
excellence through collaboration

Itinerant Services Office

1104 N. Main Street
Lombard, IL 60148-1362

Natalie Heinrich
Administrator

Mary M. Furbush, Ed.D.
Executive Director

630-629-2600, Relay Service 711
Fax 630-629-2601

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:

Natalie Heinrich
CASE Itinerant Services
1104 N. Main Street
Lombard, IL 60148
nheinrich@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,

Natalie Heinrich
CASE Itinerant Services Administrator

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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.

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REFERRAL FOR SERVICES

Student Name_____ Gender: ○ M ○ F Date of Birth_____

Home Phone: (_____)_____ Address_____ City_____ Zip_____

Parent(s)/Guardian(s):_____ Work/Cell Phone (_____)_____

Resident District: _____ Resident School: _____ Joint Agreement: _____

Attending District: _____ Attending School: _____ School Phone: (_____)_____

Attends: ○ AM ○ PM ○ Full Day School Nurse: _____ Nurse Email: _____

Teacher: _____Teacher Email: _____

Specific concerns that led to this referral: _____

_____

_____

Assessment(s) Requested – check all that apply

☐ Functional Vision Assessment

Upon receipt of the referral a Functional Vision 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: An Orientation and Mobility Assessment can be requested if the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

☐ Hearing Functioning 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 SASED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASED DuPage West Cook. Please contact SASED DuPage West Cook directly at (630) 778-4500.

Please attach this needed documentation:

___ Domain sheet and parent/guardian consent for evaluation
___ Educational screening form completed by teachers___
___ Appropriate medical information (current ocular for vision, audiological for hearing, medically relevant information)
___ Appropriate educational information (i.e. IEP, #504 plan)
___ Appropriate administrative signatures (see below)
___ Class schedule (Jr. High and High School)

Referring Person: _____ Title: _____ Date: _____

District Special Education Administrator: _____ Date: _____

Joint Agreement Director: _____ Date: _____

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Educational Screening Form for Students with Suspected or Confirmed Hearing Concerns

Student Name: _____ Birthdate: _____ Gender: Male/Female

Primary Language: _____ Grade: ____ School: _____ School Phone: (_____)_____

Teacher: _____ Current related services: _____

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

_____

_____

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

_____

_____

Please describe where the student is seated in the classroom:

_____

Does this student use an amplification device? ○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 to spoken language?	○YES ○NO
Is this child 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:

_____

_____

Additional comments and information: _____

_____

Signed: _____ Title: _____ Date: _____