



## 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

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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  
mlong@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

**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**

Vision Functioning 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 SASSED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASSED DuPage West Cook. Please contact SASSED 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: \_\_\_\_\_