**REFERRAL FORM for HEARING SERVICES**

**Email to:** Lynne Mennel,lmennel@sased.org

**Or fax/mail to**: Lynne Mennel

 2900 Ogden Avenue, Lisle, IL 60532

 **Phone #**: 630-955-8113 or 630-778-4500

 **Fax #:** 630-778-0196 or 331-903-1544

*\*\*\*\*\*THE FOLLOWING DOCUMENTATION IS REQUIRED TO BE SENT WITH THE REFERRAL REQUEST\*\*\*\*\**

 \_\_\_\_\_ Signed Parent Consent and Completed Domain Sheet

 \_\_\_\_\_ Current IEP and

 \_\_\_\_\_ Case Study Evaluation (If applicable)

 \_\_\_\_\_ Medical information:

 ~ Audiological Report(s)

 \_\_\_\_\_ Administrator Signatures

(PLEASE **CHECK (√)** THE **SERVICE YOU ARE REQUESTING**)

**ALL SECTIONS MUST BE COMPLETED.**

***\_\_\_Audiological Evaluation*** *consists of assessment of child’s hearing sensitivity, speech reception and discrimination abilities, impedance testing and, if applicable, aided performance.*

***\_\_\_Functional Listening Assessment*** *consists of an evaluation of a child’s listening comprehension of language in the school setting; through observation(s), formalized testing, and consultation with district staff. The evaluation results will assist in recommendations regarding itinerant services, trial use of an assistive listening device, and accommodations related to the student’s hearing loss.*

## STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F: \_\_\_\_\_\_\_ DATE of BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (STREET) (CITY) (ZIP)

PARENT/GUARDIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BEST METHOD TO CONTACT:\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN PREFERRED LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT PREFERRED LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_

INTERPRETER NEEDED: YES: \_\_\_\_\_ NO: \_\_\_\_\_ DISTRICT OF RESIDENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name & District #)

STUDENT HOME SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ATTENDING SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT CURRENT PLACEMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Type of Program: Gen Ed; Self-contained; etc.)**

RELATED SERVICES STUDENT RECEIVES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIC CONCERNS/QUESTIONS TO BE ADDRESSED BY THIS REFERRAL: (Must be completed.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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TEACHER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BEST TIME TO CALL:\_\_\_\_\_\_\_\_

TEACHER REPORT:

Please 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe where the child is seated in the classroom. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a medical condition that may affect hearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SO THAT THE EVALUATION CAN ADDRESS SPECIFIC ISSUES, PLEASE ANSWER THE FOLLOWING TO THE GREATEST EXTENT POSSIBLE:

Does the student wear hearing aid(s)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, is the hearing aid(s) worn consistently? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the student have difficulty with:

 Listening in the presence of noise? \_\_\_\_\_ Yes \_\_\_\_\_ No

 Following verbal directions? \_\_\_\_\_ Yes \_\_\_\_\_ No

 Discriminating similar sounding words? \_\_\_\_\_ Yes \_\_\_\_\_ No

 Starting a task without watching peers

 or asking for help? \_\_\_\_\_ Yes \_\_\_\_\_ No

 Responding to spoken language without

 visual cues? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does this student become easily frustrated? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is this student’s attention span shorter than peers? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is this student more distractible than peers? \_\_\_\_\_ Yes \_\_\_\_\_ No

OTHER STUDENT CONCERNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(i.e.: Medical; Behavioral; Allergies; Anxieties; etc.)**

Person Making the Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PLEASE PRINT)

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best time to call:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Building Principal/ Date Signature of Director of Special Education/ Date

*If there is any missing documentation, it WILL delay scheduling.* If there are previous evaluations or current therapy reports/IEP for the student, please forward with the referral to facilitate assessment procedures and to prevent duplication.

***Be sure to enclose a signed parent consent form***

***and a***

***completed domain page.***

Rev. 11/16/2016