1381 Cleaver Road Caro, MI 48723 PH. (989) 673-5200 (Fax) 989-672-4603

REQUEST FOR INDIRECT AUDIOLOGICAL SERVICE

Return or Fax this completed form to our Audiology Department

Please Check:

- ☐ **Central Auditory Processing Evaluation - (Please complete attached for**
- ☐ **Hearing Evaluation**
- ☐ **Screening**

Please Print

Request Date: _____-_____-_____

Requested By:_____

Student Name:_____ **Attending District:_____** **Grade:_____**

Birthdate: _____-_____-_____ **Sex: _____** **Building:_____**

Race/Ethnic Group:_____ **Contact Teacher:_____**

Address:_____ **Home Phone: _____-_____-_____**

Town:_____Zip Code: _____ **Cell Ph: _____-_____-_____**

Parent(s) /Guardian Name: **Work Ph: _____-_____-_____**

_____ **Msg. Ph: _____-_____-_____** **Relationship_____**

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PERSONNEL REQUESTING EVALUATION

BRIEFLY DEFINE THE PROBLEM (state intensity, duration and frequency of behavior) BE SURE TO COMPLETE THE REVERSE SIDE OF THIS REQUEST

_____ Your Signature

_____ Principal's Signature

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FOR AUDIOLOGIST USE ONLY

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Is this student's current level of academic achievement significantly below his/her present grade placement? YES____ NO__
If yes, by approximately how much?_____
Does this student display average or near average intellectual ability as indicated by verbal expressions, general knowledge, comprehension and non-verbal reasoning? YES_____ NO_____
Please check if the student shows evidence of the following characteristics:

____Perceptual handicap	____Persistent distractibility	____Short attention span
____Poor balance/coordination	____Disorganization	____Impulsivity
____Spelling Difficulties	____Reading Difficulties	____Poor word attack skill
____Poor auditory/visual information processing ability		____Hyperactivity
____Inability to follow directions completely or in correct sequence		

Comments:_____
_____

EDUCATIONAL INTERVENTION:

Please check the strategies which have been attempted thus far to solve the problem:

____Title Programs	____Individual instruction	____Community Agencies
____Team Teaching	____Adapted Materials	____Occupational Therapy
____Adult Tutor	____Alternative Materials	____Physical Therapy
____Student Tutor	____Parent Assistance	____Speech Therapy
____Remedial Reading	____Change in classroom seating	

Describe any health or physical problems/observations:_____
_____
Did the student pass or fail (circle one) his/her last hearing screening at school?
Date of last hearing screening:_____ Does the student use a hearing aid? YES_____ NO_____
Why do you suspect a hearing problem? _____
_____
Does the student's hearing seem to fluctuate? YES____ NO____
Does he/she have frequent Colds_____ Allergies _____ Ear Infections _____

Other Comments or information which might be helpful for the audiologist:_____
_____

PARENTAL CONSENT TO EVALUATE

Dear _____ Date:_____
Parent/Guardian
To assist us in determining a more appropriate teaching environment in which to educate your_____
Son/Daughter

_____has referred_____to
Person/Agency Name Student
_____Educational evaluation department. We seek this evaluation to
School District/LEA/ISD
Help _____ Reason for Referral: _____
Student

_____
Signature of School Representative

_____
School District Address City State Zip

I (we) grant permission for _____to conduct an educational evaluation on behalf of my (our) child. I (we) further understand that this consent is voluntary and can be withdrawn at any time.

_____ _____
Legally Responsible Adult Signature(s) Date

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When referring a student for an Auditory Processing Evaluation – Please complete this form:

COMMUNICATION CHECKLIST FOR THE AUDIOLOGIST

Person Completing this Form:_____ Date:_____

Student Name:_____Birthdate:_____School_____Grade_____

CHECK ALL THAT APPLY:

☐ The SIFTER / FISHER / CHAPS was filled in and returned to the audiologist by_____.
☐ The Student is in academic struggle. (If the student is not in academic struggle, the disability my be identified, but not served, as there may be no educational need).
☐ The student is labeled as Learning Disabled, but is not successful in the Learning Support Classroom.
☐ The student has a normal IQ and is not previously diagnosed as having Neurological Impairment, Pervasive Development Delay, Autism, or other disability that would preclude a differential diagnosis.
☐ The student has normal hearing in both ears.
☐ The student has a history of ear infections and has/ has not had PE tubes placed _____times.
☐ The student has difficulty following verbal instructions or directions.
☐ The student has difficulty listening in noise.
☐ The student has weaknesses in the following areas: (Check all that apply):
☐ READING ☐ SPELLING ☐ LANGUAGE ☐ MATH OTHER _____

Please list all medications the student is currently taking:_____
_____.

☐ If the student is usually on medication daily, prior to this evaluation, PLEASE NOTIFY THE NURSE & THE PARENT TO CONTINUE THE MEDICATION.

Does the student have a medical or educational diagnosis? YES ___NO__
If the answer is "YES", what is the diagnosis?_____

Persons requesting the referral are: ___Psychologist ___Teacher ___IST Team ___Parent __Dr.(Specify _____)
___Speech Therapist ___Other

AUDITORY PROCESSING EVALUATIONS TAKE APPROXIMATELY 1.5 – 2 HOURS. PARENT/GUARDIAN IS REQUESTED TO STAY WITH THE CHILD DURING THE EVALUATION.

TISD: 11-11