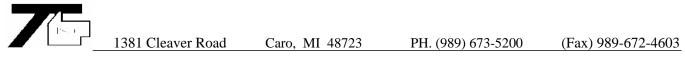


REQUEST FOR INDIRECT AUDIOLOGICAL SERVICE

Return or Fax this completed form to our Audiology Department Please Check: Central Auditory Processing Evaluation - (Please complete attached for **Hearing Evaluation Screening Request Date:** ____-_ Please Print 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_____ 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

FOR AUDIOLOGIST USE ONLY

Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD Help Student School District Address	has referreEducational evaluation Reason for Referral: Cityto conduct an educational eva	Student department. We seek this evaluation to Signature of School Representative State Zip aluation on behalf of my (our) child. I (we) further
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD Help Student School District Address	has referredhas referred	Student department. We seek this evaluation to Signature of School Representative State Zip
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD Help Student	has referrehas referrehas referre	Student department. We seek this evaluation to Signature of School Representative
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD Help	has referre Educational evaluation	Student department. We seek this evaluation to
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD Help	has referre Educational evaluation	Student department. We seek this evaluation to
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name School District/LEA/ISD	has referre Educational evaluation	Student department. We seek this evaluation to
Parent/Guardian To assist us in determining a more appropriate Son/Daughter Person/Agency Name	has referre	Student
Parent/Guardian To assist us in determining a more appropriate Son/Daughter	has referre	Student
Parent/Guardian To assist us in determining a more appropriate	-	ed to
Parent/Guardian To assist us in determining a more appropriate	e teaching environment in which to	
Parent/Guardian	a taaching anvironment in which to	cuucate your
		educate vour
Dear		Date:
I	PARENTAL CONSENT TO EVA	LUATE
Other Comments or information which might	be helpful for the audiologist:	
<u>-</u>	_	Ear Infections
Does the student's hearing seem to fluctuate?	YES NO	
Why do you suspect a hearing problem?		
Date of last hearing screening:	Does the stude	ent use a hearing aid? YESNO
Did the student pass or fail (circle one) his/her		
Describe any health or physical problems/obse	ervations:	
Remedial Reading	Change in classroom seating	
Student Tutor	Parent Assistance	Fhysical Therapy Speech Therapy
Team TeachingAdult Tutor	Adapted MaterialsAlternative Materials	Occupational TherapyPhysical Therapy
	Individual instruction	Community Agencies
EDUCATIONAL INTERVENTION:		
Comments:		
Inability to follow directions co	mpletely or in correct sequence	**
Spelling DifficultiesPoor auditory/visual information		Poor word attack skillHyperactivity
Poor balance/coordination	Disorganization	Impulsivity
i ciceptuai nandicap	Persistent distractibility	Short attention span
Perceptual handicap	the following characteristics.	
	the following characteristics:	
omprehension and non-verbal reasoning? YE Please check if the student shows evidence of	ES NO	
f yes, by approximately how much? Does this student display average or near aver omprehension and non-verbal reasoning? YEPlease check if the student shows evidence of	ES NO	by verbal expressions, general knowledge,



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 wa	as filled in and returned to the a	udiologist by	·		
☐ The Student is in academic struggle.	(If the student is not in academ	nic struggle, the disabilit	y my be identified, but		
not served, as there may be no educa	ntional need).				
The student is labeled as Learning D	isabled, but is not successful in	the Learning Support C	Classroom.		
The student has a normal IQ and	d is not previously diagnosed	d as having Neurologic	cal Impairment, Pervasive		
Development Delay, Autism, or other	er disability that would preclud	e a differential diagnosis	S.		
The student has normal hearing in b	ooth ears.				
☐ The student has a history of ear infe	ections and has/ has not had PE	tubes placedtir	nes.		
The student has difficulty following	verbal instructions or directions	s .			
☐ The student has difficulty listening in	n noise.				
The student has weaknesses in the fo	ollowing areas: (Check all that a	apply):			
READING SPELLING	LANGUAGE MATH	OTHER			
Please list all medications the student is					
☐ If the student is usually on medicating THE PARENT TO CONTINUE THE	on daily, prior to this evaluation				
Does the student have a medical or educ	ational diagnosis? YESNO)			
If the answer is "YES", what is the diag	nosis?				
Persons requesting the referral are:F	PsychologistTeacherIS Speech TherapistOther	T TeamParentD	Or.(Specify)		

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