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

Comments:_____

EDUCATIONAL INTERVENTION:

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

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

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) f
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: (Circle 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.