Deaf / Hard of Hearing Referral Form
Educational Service District 123 Audiology Program

Student Information:

Child's Full Name:
Address:
City / Zip:
Birthdate:
Gender: ☐ Male ☐ Female

Mother's Full Name:
Mother's Phone Number:
Email Address:
Father's Full Name:
Father's Phone Number:
Preferred Contact: ☐ Mother ☐ Father

Child's Primary Care Physician:
Physician's Address:
Physician's Phone Number:

School Information:

School:
School District of Residence:
Currently in place: ☐ IEP ☐ 504 ☐ None
Bilingual / ESL/ ELL? ☐ Yes ☐ No
Is wheelchair access needed? ☐ Yes ☐ No

Teacher Name:
Grade:
Primary Language:
Interpreter needed? ☐ Yes ☐ No

Special education service(s) student currently is receiving:

☐ Occupational therapy ☐ Physical therapy ☐ Speech/Language ☐ Vision
☐ Learning disability ☐ Social work ☐ Assistive technology
☐ Other

Referral Source (person completing this form):

Name:
School:
Email Address:
Parents were notified of this referral on (date) by (name):

Title:
Address:
Phone:

Request for Audiologic Evaluation:

☐ Student or family does not have a recent hearing evaluation
☐ Family is experiencing barriers to accessing audiology services
☐ Student has failed multiple hearing screenings and has not completed a hearing evaluation
☐ Student cannot complete hearing screening ☐ Young child (ages < 5 years)

Signatures:

Referral Source:
Authorized Administrator:

Date:
Date:

Please attach relevant records including prior reports, current domain/consent and/or active IEP or 504 plan, when applicable. Email referral packet to Betsy Schluge at audiologicalassessments@esd123.org or fax to 509-544-5792.