Capital Region ESD 113

Deaf / Hard of Hearing Referral Form

Capital Region Educational Service District 113 Audiology Program

Student Information:

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

Mother's Full Name:
Mother's Phone Number:
Email Address:
Father's Full Name:
Father's Phone Number:
Email Address:
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 is currently receiving:

☐ Occupational Therapy
☐ Learning Disability
☐ Other:
☐ Physical Therapy
☐ Social Work
☐ Speech/Language
☐ Assistive Technology
☐ Vision

Referral Source (person completing this form):

Name:
School:
Email Address:
Parents were notified of this referral on

Title:
Address:
Phone:
(date) by (name):

Request for Audiological Services:

☐ 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 has a diagnosed hearing loss and needs monitoring and equipment check
☐ Student needs a functional listening evaluation to determine appropriate accommodations
☐ Review of student's IEP/504 plan

Signatures:

Referral Source:
Date:
Authorized Administrator:
Date:

Please attach relevant records including prior reports, current domain/consent and/or active IEP or 504 plan, when applicable. Email referral packet to Juli Aselton at jaselton@esd113.org.