Request for Educational Audiology Evaluation

Student Name: _____ Date of Referral: _____ School District: _____

DOB: _____ Parent/Guardian Name: _____

Parent/Guardian Contact Information

Home Phone: _____ Cell: _____ Work: _____

Parent/Guardian Email: _____

Parent/Guardian Address: _____

School: _____ Grade: _____ School Year: _____

Teacher Contact: _____

Please select one of the following:

- ☐ Comprehensive Educational Audiology Evaluation for child with suspected hearing loss
- ☐ Central Auditory Processing Evaluation
- ☐ Educational Audiology Evaluation to determine benefit of digital modulation hearing assistive technology (DM HAT) includes 60 day trial
- ☐ Audiology Consultation Only - Number of Audiology Consultations Requested: _____

Please attach:

* Current (within 12-24 months) Speech-Language Evaluation Report (to include receptive and expressive language)
* Current (within 12-24 months) Psychological and Psycho-Educational (either or both)
* Any previously completed Audiology or Hearing Evaluations
* Any additional pertinent school based or outside evaluations

___ Speech Language Evaluation is in process (district will communicate with Audiologist on results)

___ Psychological Evaluation is in process (district will communicate with Audiologist on results)

_____	_____	_____
Name of Team Contact Person/Position	Signature	Date
_____	_____	_____
CSE Chairperson	Signature	Date
_____	_____	_____
Parent/Guardian	Signature	Date

If you have any questions or require additional information about the referral process, please do not hesitate to contact Hearing Evaluation Services, Dr. Christine Pleban at cpleban@hesofbuffalo.org or 716-833-4488 request ext. 516.

Once form complete, please fax to 716-839-1218 or email cpleban@hesofbuffalo.org. Attention: Christine Pleban

4/18/2023