AUDIOLOGICAL REFERRAL AND PARENT CONSENT

_____ has been referred to the ESU 16 Audiologist for more in-depth testing to determine if there is a hearing problem. Testing is scheduled in North Platte.

Referral Source _____ _____
Name Position

THIS REFERRAL FORM MUST BE APPROVED
BY THE LOCAL SCHOOL DISTRICT BEFORE SENDING IT TO ESU 16.
PLEASE RETURN TO: ESU #16, Attn: Audiology, 1221 W. 17th St., North Platte, NE 69101

Referral Reason:

☐ Pure Tone Testing
☐ Hearing Aid Testing
(bring hearing aid/s)

☐ Auditory Trainer Testing
(bring all parts of the auditory trainer)

☐ There are special circumstances which may require extra time or assistance in testing.
Comments: _____

School Audiogram: (if available)

	250	500	1000	2000	4000	6000	8000
R							
L							

Date: _____

Name _____ School _____ Grade ___

Teacher _____ Birthdate _____ Age _____ Sex _____

Parent(s)/Guardian _____ Address _____
Name Street/Route

_____ _____ _____
City State Zip

Phone where parent may be reached from 8:00 a.m. – 5:00 p.m. _____

Home Phone (if different from the one listed above) _____

CASE HISTORY

Does your child have:

A. Known Hearing Loss ☐ Yes ☐ No
(If yes, please provide audiograms from past years.)

History of Ear Infections _____

Tubes ☐ Yes ☐ No

B. Allergies/Upper Respiratory Infection _____

Case History, continued.

C. Is your child taking any medication? ☐ Yes ☐ No

D. Medical conditions _____

Syndrome _____Other _____

E. Head Injuries and/or serious illness _____
_____

F. Hearing Aid ☐ Yes ☐ No **If yes, bring hearing aid to the test**.
Auditory Trainer ☐ Yes ☐ No **If yes, bring to the test**.

G. Exposure to noise ☐ Yes ☐ No

H. Is there a history of hearing loss in the family other than old age?
☐ Yes ☐ No

I. Name and Address of Physician(s): _____
_____
_____

Has your child had a hearing test by a doctor or audiologist in their office previously?
☐ Yes ☐ No Please send or bring a copy of the test results to ESU 16 on or before your child's test date.

J. Is your child in:
☐ Speech/Language Therapy Teacher's Name _____
☐ Resource Teacher's Name _____
☐ Chapter I Teacher's Name _____

PARENT AUTHORIZATION

I, (we), _____, the legal parent(s)/guardian(s) of _____ do hereby authorize the ESU 16 Audiologist to conduct a complete hearing evaluation. I (We) hereby authorize the ESU 16 Audiologist to release all audiological information to agencies or individuals who are functioning to habilitate my (our) child and to obtain all testing information from these agencies or individuals pertaining to my (our) child.

_____ _____
Date **Signature of Parent(s)/Guardian(s)**

_____ _____
Date **Signature of School District Administrator**