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):_____

Referral Reason:
___ Pure Tone Testing
___ Auditory Trainer Testing (bring all parts of the auditory trainer)
___ Hearing Aid Testing (bring hearing aid/s)
___ Central Auditory Processing Evaluation

___ Are there special circumstances which may require extra time or assistance in testing?
Comments: _____

School Audiogram (if available): Date_____

1000 Hz	2000 Hz	4000 Hz
Right		
Left		

Name _____School _____ Grade ___

Teacher _____ Birthdate _____ Age _____ Sex _____

Parent(s)/Guardian _____ Address_____

_____ _____ _____
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 _____

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(s) 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): _____
_____
_____

J. Is your child in:
___Speech/Language Therapy Teacher's Name _____
___Resource Teacher's Name _____
___Title I Teacher's Name _____

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.)

_____

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**

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

Or email/scan to: dschmitt@esusixteen.org