Center for Instruction, Technology & Innovation

AUDIOLOGY EVALUATION REFERRAL FORM

School Year: _____/_____
Student Name: _____ DOB: _____

School District: _____ School District ID: _____

Parent/Guardian Contact Information

Parent/Guardian Name: _____

Cell: _____ Home: _____ Email: _____

Parent/Guardian Address: _____

School Building in Attendance: _____ Grade: _____

Teacher Contact: _____

Please select one of the following:

☐ Audiology Evaluation for a Child with a Hearing Loss - For districts with a district Teacher of the Deaf (TOD) or without a district TOD

☐ Central Auditory Processing Evaluation

Please attach:

* Current (within 12-24 months) Speech-Language Evaluation Report (to include receptive and expressive language)

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

* Current (within 12-24 months) Psychological and Psycho-Educational (either or both)

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

* Any previously completed Audiology or Hearing Evaluations
* Any additional pertinent school based or outside evaluations
* IEP/504 Emailed and/or Shared w/the school district assigned Educational Audiologist

For Non-CiTi Students: Make a copy and submit the original to your CSE Chairperson for review and signature.

For Students placed in a CiTi program: Make a copy and submit the original to your CiTi supervisor for their review and signature.

_____	_____	_____
Name of Team Contact Person/Position	Signature	Date
_____	_____	_____
CSE Chairperson	Signature	Date
_____	_____	_____
CiTi Supervisor (if CiTi student)	Signature	Date

If you have any questions or require additional information about the referral process, please do not hesitate to contact Deborah McConnell, Audiology Department Sr Typist at (315) 963-4456 or dmcconnell@citiboces.org
Email completed form to dmcconnell@citiboces.org or fax to (315) 963-4464