



Audiology Evaluation Referral Form

Student Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_ School District: \_\_\_\_\_

DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Contact Information: Phone: (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

Please select one of the following:

\_\_\_\_ New Referral for a Student with a Hearing Loss (Includes additional diagnostic testing in the sound booth if needed, classroom observation, functional listening evaluation, hearing assistance technology evaluation, classroom acoustic evaluation, consultation with educational team, and consultation with parent(s) or guardian(s).

\_\_\_\_ New Referral for a Student with suspected Central Auditory Processing Disorder (Includes comprehensive diagnostic central auditory processing evaluation, classroom observation, functional listening evaluation, hearing assistance technology evaluation, classroom acoustic evaluation, consultation with educational team, and consultation with parent(s) or guardians(s).

Please attach the following for either referral:

- 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
- \_\_\_\_\_ Please send current IEP or 504 if student is currently classified
- \_\_\_\_\_ 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)

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
_____	_____	_____
Parent/Guardian Signature	Signature	Date

If you have any questions or require additional information about the referral process, please do not hesitate to contact:  
Audiology Team Leader: Dr. Amy Bradbury, Au.D. CCC-A Email: [abradbury@citiboces.org](mailto:abradbury@citiboces.org) Cell: 315.591.5771