AUDIOLOGICAL REFERRAL to the Sertoma Speech and Hearing Center

☐Hearing Screening Could not test due to: ☐ Age ☐ Could not condition ☐Multi-need ☐Needs additional testing

☐Hearing Evaluation Reason: ☐ Annual eval ☐ Case study ☐ Reported hearing loss ☐ Failed school screening

☐Hearing Aid Check Reason: ☐ Maintenance check ☐ Not working (please explain) _____

☐FM Evaluation Reason: _____

☐FM Aid Check Reason: ☐ Maintenance check ☐ Not working (please explain) _____

☐Earmold Impressions: Reason: ☐ For FM system ☐ For booted FM system

☐Evaluation for Auditory Processing Reason: _____

Special considerations for this testing: **MUST BE: 1) 7 years old 2) Proficient in English 3) No known hearing loss 4) No other cognitive impairments.** These factors may impact the validity of the APD testing . A diagnosis will not be given unless it can be ruled out that these factors did not impact the test. Contact Sertoma if there are questions about test validity.

☐

Student Name (first last): _____ DOB: _____ Sex: ☐Male ☐Female

Parent/Guardian Name: _____ Home phone: _____ Work phone: _____

Address: _____ City/Zip: _____

District: _____ School Attending: _____

School Address: _____ School phone:

Current grade/Placement: _____ Regular Education student? ☐Y ☐ N

Special Ed. Program? ☐Y ☐ N Related services: _____

Does the student wear hearing aid(s)/cochlear implant(s)/bone anchored aid(s)? ☐Y ☐ N

Please specify what is used: _____

Can this child press a button when a sound is heard and sit unassisted on a chair? ☐Y ☐ N

(If NO, this gives us permission to supply 2 testers for the appointment)

Does the student require wheelchair assistance? ☐Y ☐ N

REASON FOR REFERRAL: _____

FORWARD TO SERTOMA AFTER ALL REQUIRED SIGNATURES OBTAINED

Referred by: _____ Title: _____ Phone: _____

Address: _____ City, Zip _____

District representative: _____ Date: _____

Parent/guardian: _____ Date: _____

☐ Can obtain phone consent (optional) _____ _____

Cooperative Representative: Date:

Sertoma will forward copies of audiological report(s) to:

- District and/or Co-operative Representative
- Referring Party
- Parents/Guardians

Sertoma Use Only:
Appointment Scheduled:
_____
_____
_____

- ✓ If upon reviewing child information, the above checked appointment is not necessary, the audiologist will modify and schedule the child as appropriate. *Sertoma will notify the district of any scheduling modifications.*
- ✓ If the child fails a hearing screening, Sertoma will automatically conduct or schedule a full diagnostic hearing assessment.
- ✓ If the child utilizes amplification, Sertoma will automatically perform a hearing aid check (an additional ½ hour) in conjunction with a hearing evaluation.
- ✓ This referral is good for one year from the date of signature. Should a student move out out district, the district is responsbile to notify Sertoma to cancel this referral.

I understand the above will be conducted unless the following box is checked and signed ☐_____

District Representative