

Consultant for the Deaf and Hard of Hearing Referral Form

NAME: _____ BIRTHDATE: _____ SEX: _____ GRADE: _____
Family Name Given Name Day Month Year

ADDRESS: _____ PHONE NUMBER: _____
Postal Code

WORK NUMBER: _____

FATHER'S NAME (Guardian): _____ MOTHER'S NAME (Guardian): _____

SIBLINGS (Name, age): _____

LANGUAGES SPOKEN IN HOME: _____ CHILD'S COMMUNICATION METHOD
(ASL, Oral, Other): _____

SCHOOL: _____ SCHOOL DIVISION: _____

TEACHER: _____ PRINCIPAL: _____

RESOURCE TEACHER: _____ AUDIOLOGIST: _____

TYPE OF AMPLIFICATION: _____

OTHER MEDICAL/PHYSICAL CONDITIONS: _____

OTHER PROFESSIONALS/AGENCIES INVOLVED: _____

1) REASON FOR REFERRAL: _____

2) EXPLAIN LANGUAGE, SPEECH AND HEARING DIFFICULTIES OBSERVED AND UNDER WHAT CIRCUMSTANCES: _____

3) ACADEMIC DEVELOPMENT (Strengths and weaknesses): _____

4) PLEASE INDICATE WHAT SPECIFIC HELP YOU WISH TO OBTAIN BY THIS REFERRAL: _____

5) PLEASE INCLUDE A COPY OF THE MOST RECENT AUDIOLOGICAL ASSESSMENT.

Signature of parent or guardian agreeing to this referral: _____ Date: _____

Signature of school personnel making referral: _____ Position: _____ Date: _____

