

Date Received:

Referral for Audiology Services

(Please fill out form completely)

Date of Request:

School District:

This is a service request for: Audiology Evaluation FM Equipment Other

Contact Information

Person Requesting Services:

Position/title: (teacher, nurse, etc.):

Email Address:

Phone:

Please indicate the specific reasons and/or situations which prompted you to initiate this request for service, and the specific objectives expected to be accomplished.

Student Information

Student Name:

DOB:

MARSS Number:

Student's School Name:

Grade:

Student's Home Address:

Parent and/or Guardian Name:

Home Phone #:

Cell Phone #

Email

ACCOMMODATIONS NEEDED FOR VISIT

Please specify any accommodations that may be required to support the student's and/or the parent need with the audiology office. Accommodations may include an American Sign Language Interpreter for the student and/or parent, or a language interpreter for the student and/or parent. Please be specific with your request. The referring school district will be billed for audiology costs plus any accommodations that may be specified and requested.

Accommodations needed: _____

- ◆ For an initial assessment, please attach to this request a copy of the school hearing screening results
- ◆ If service is required as part of a Special Education Assessment Plan, attach this form to the Special Education Assessment/Reassessment Planning Form.
- ◆ A copy of the audiology report will be mailed to the student's parents and the person requesting the referral. Please indicate below any other person(s) who should receive a copy of the report.

◆ Name: _____ Address: _____

This request has been authorized by:

(Director of Special Education)

Date

MAIL OR FAX THE COMPLETED FORM TO:

Deaf/Hard of Hearing & Blind/Visually Impaired Services
 Northeast Metro 916 Intermediate School District
 Quora Education Center
 70 West County Road B2 | Little Canada, MN 55112
 Phone 651-415-5546 | Fax 651-415-5509