

**AUDIOLOGICAL REFERRAL AND PARENT CONSENT**

\_\_\_\_\_ has been referred to the ESU 10 Audiologist for more in-depth testing to determine if there is a hearing problem. Testing is scheduled in Kearney. Candice Meier, ESU 10 Secretary, will be calling you to set up an appointment after she receives this form.

**Referral Source:** \_\_\_\_\_

Name

Position

**THIS REFERRAL FORM MUST BE APPROVED BY THE LOCAL SCHOOL DISTRICT BEFORE SENDING IT TO ESU 10.**

**REFERRAL REASON:**

- Pure Tone Testing                       FM/DM system testing  
 Hearing Aid Testing                      (bring all parts )  
(bring hearing aid/s)

- There are special circumstances that may require extra time or assistance in testing, such as cognitive, or language delays, attention, etc.

**Please explain:**

**Attach school screening if available.**

**Name:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Parent(s)/Guardian Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone where parent can be reached from 8:00 AM to 5:00 PM**

\_\_\_\_\_

**Cell or work phone (if different from the one listed above)**

\_\_\_\_\_

**Does the parent speak English?**  yes  no

**CASE HISTORY**

**Does your child have:**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Known Hearing Loss (If yes please provide audiograms from the past years)
<input type="checkbox"/>	<input type="checkbox"/>	History of Ear Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Tubes _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies /Upper Respiratory Infection _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your child taking any medications? List: _____ _____

Medical Conditions \_\_\_\_\_

Syndrome \_\_\_\_\_

Head injuries and / or serious illness (if so briefly explanation) \_\_\_\_\_

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid <b>If yes bring hearing aid to test</b>
<input type="checkbox"/>	<input type="checkbox"/>	FM/DM System <b>If yes bring to test</b>
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to noise, hunting, tractors, machinery, etc. describe _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Is there a history of hearing loss in the family other than old age?

Name and address of physician(s):  
\_\_\_\_\_

Has your child had a hearing test by a doctor or audiologist previously? yes no If yes please send or bring copy of the test results on or before your child's test date.

Is your child in:

<input type="checkbox"/> Speech / Language Therapy	Teacher's Name _____
<input type="checkbox"/> Resource	Teacher's Name _____
<input type="checkbox"/> Service Coordinator	Teacher's Name _____

**IEP Due Date** \_\_\_\_\_ **MDT Due Date** \_\_\_\_\_

**PARENT and SCHOOL AUTHORIZATION**

I, (we) \_\_\_\_\_ the legal parent(s) / guardian(s) of \_\_\_\_\_

Do hereby authorize the audiologist to conduct a complete hearing evaluation. I (we) hereby authorize the audiologist to release all audiological information to agencies or individuals who are functioning to habilitate my (our) child and to obtain all testing information from these agencies or individuals pertaining to my (our) child. I understand that any medical recommendations or referral for further medical follow-up will be my responsibility and not that of the school or ESU #10.

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Signature of Parent(s) / Guardian(s)**

I understand that these audiology services are offered at no charge to the parent and are at no additional cost to schools within the ESU 10 area. However, if the school is outside of ESU 10 area there will be a per hour fee charged to the school district.

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Signature of School District Administrator**

Please return the completed and signed form to the school district. The school district can then route, mail, fax or email this completed and signed form to ESU 10, Attn: Audiology, 76 Plaza Blvd. PO Box 850, Kearney, NE 68848. Fax: 308-237-5920. Email: [cmeier@esu10.org](mailto:cmeier@esu10.org)