ESU10
Our focus is on Serving you!

EDUCATIONAL SERVICE UNIT 10
76 Plaza Boulevard PO Box 850
Kearney, NE 68848-0850
Ph. 308.237.5927 Fax 308.237.5920
www.esu10.org

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

☐ 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:** Choose One

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:

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

_____

Medical Conditions _____

Syndrome _____

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

_____

YES	NO	
☐	☐	Hearing Aid **If yes bring hearing aid to test**
☐	☐	FM/DM System **If yes bring to test**
☐	☐	Exposure to noise, hunting, tractors, machinery, etc. describe _____

_____

☐	☐	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:

☐ Speech / Language Therapy Teacher's Name _____

☐ Resource Teacher's Name_____

☐ 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