

Hearing Screening Program Audiology Referral

Area: _____ School Location Number: _____ Area Use Only: _____
 School Number: _____ Student Name: _____
LAST FIRST M.
 Referral Date: _____ Referred by: _____ (1 – Nurse, 2 – S.L.P., 3 – Other)
 School: _____ Grade: _____ Sex: _____ DOB: _____
 Address: _____ Zip: _____ Home Phone: _____
 Parents/Guardian: _____ Work Phone: Mother _____ Father _____
 Does Student/Parent Need Interpreter: _____ Explain: _____

_____ Student Receives **NO** Special Education Service

_____ Student Receives Special Education Service (To Include the following: Speech/Language Therapy, Occupational Therapy, Adaptive P.E., Physical Therapy, Resource Room, Part-time or Full-time Special Education Classroom)

Date: _____ By: _____

Parent Has Been Notified of this Referral: _____ By Phone _____ By Note/Mail _____ In Person

1st Hearing Screening Date: _____ Pass Fail

FREQUENCY

	500		1000		2000		4000		6000	
L - Ear	P	F	P	F	P	F	P	F	P	F
R - Ear	P	F	P	F	P	F	P	F	P	F

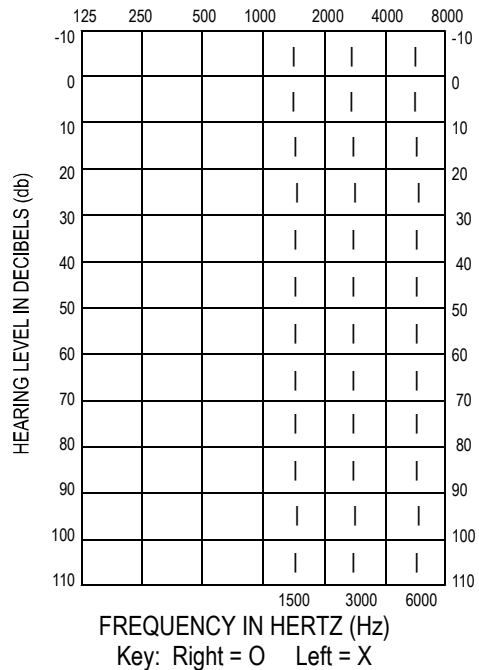
2nd Hearing Screening Date: _____ Pass Fail

FREQUENCY

	500		1000		2000		4000		6000	
L - Ear	P	F	P	F	P	F	P	F	P	F
R - Ear	P	F	P	F	P	F	P	F	P	F

Comments: _____

PURE TONE AUDIOGRAM (RE: ANSI 1969)



Referred by/TITLE: _____ Principal's Signature: _____

Date: _____