Exceptional Student Education & Student Services
SANTA ROSA COUNTY SCHOOL DISTRICT

Audiology Clinic Referral Form

Fax to 850-983-7007, Attn: Audiology Clinic

NAME: _____**DOB:** _____**REFERRAL DATE:** _____

SCHOOL: _____**GRADE:** ____ **REFERRED BY:** _____
PRINT NAME

ESE PROGRAM(S) CURRENTLY ENROLLED: _____

MEDICAL DIAGNOSIS: _____

STUDENT HAS: _____ HEARING AIDS _____CLASSROOM SOUNDFIELD SYSTEM
_____ COMMUNICATION DEVICE(S) _____PERSONAL FM SYSTEM
*TYPE:*_____

PARENT CONTACT INFORMATION: _____

_____

STUDENT:
____ Failed two consecutive hearing screenings at any one frequency tested (1000, 2000, or 4000 Hz) at 20 dB.
____ Teacher or parent questions hearing because the student appears to have difficulty understanding instruction.
____ Student has chronic colds and/or otitis media that may have an impact on hearing.
____ A sibling or other relative has a known hearing loss.
____ The student exhibits auditory problems significantly impacting achievement.
____ Routine three year re-evaluation for Deaf or Hard of Hearing student
____ Out-of-county, out-of-state transfer with known hearing loss

Hearing screening results:_____
Other hearing problems:_____

Communication
Student uses the following means of communication: (check all that apply)
___ gestures **____ intelligible speech** **_____ vocalizations**
___ American Sign Language **____ semi-intelligible speech** **_____ facial expression**
___Family language if other than English: _____

Additional Notes:
_____
_____
_____