

Date Referral Received
From School District: _____

Date Referral emailed/mailed
To educational audiologist _____

REFERRAL FOR HEARING SUPPORT SERVICES

Service(s) Requested:

- Determination of Eligibility
 Audiology only (check only if you are a school district with own Teacher of the Deaf/HH)
 Other (please specify): _____

IMPORTANT! PLEASE ATTACH ALL CLINICAL HEARING TEST RESULTS FOR REVIEW
 (A recommendation cannot be made without a recent clinical audiogram and report provided by parent)

PLEASE DO NOT SEND A PERMISSION TO EVALUATE FORM UNTIL CONTACTED BY THE HEARING OFFICE.

Student Last Name:		Student First Name:		DOB:
Grade:	School:	School Phone No:		
District:		Parent/Guardian:		
Street Address:				
City/State/Zip:		Cell #:	Email:	
SS# or Student ID# (Optional):		Home #:	Work #:	
District Contact:		Phone #:	Email:	

Transfer Students only: Please attach current ER/IEP

From Within PA: Yes No
 Amount of Hearing Support Services designated on IEP: _____

Place a "√" next to the services which the student currently receives.

Place an "X" next to the services for which the student is currently being evaluated.

- | | |
|--|---|
| (11) _____ Academic Gifted Support | (10) _____ Blind or Visually Impaired Sensory Support |
| (01) _____ Academic Learning Support | (07) _____ Speech & Language Support |
| (02) _____ Life Skills Support | (08) _____ Physical Support |
| (04) _____ Emotional Support | (26) _____ Autistic Support |
| (06) _____ Deaf or Hard of Hearing Support | (03) _____ Multi-handicapped Support |

Additional Comments: _____

DISTRICT LIAISON/SUPERVISOR SIGNATURE _____ **Date:** _____

The LEA's signature authorizes the AIU to conduct the evaluation. If this form is emailed by the LEA/designee, the email will be considered as authorization to proceed.

**This form can be emailed as an attachment to DHHreferral@aiu3.net or faxed to (412) 394-5783
 If you have any questions, please feel free to call Ms. Milbert at (412) 394-5843**