Tools For Schools

COCHLEAR IMPLANT AUDIOLOGY REFERRAL FORM

Student Name: ______________________________ Date: ______________

Requested By: ____

Educator Phone Number or Email: ______________________________

Reason for referral

(check all that apply and provide specific examples or details)

- [ ] Equipment problem: ______________________________
- [ ] Changes in sound awareness: ______________________________
- [ ] Changes in classroom or therapy behavior: ______________________________
- [ ] Changes in speech recognition: ______________________________
- [ ] Changes in speech production: ______________________________
- [ ] Changes in processor settings: ______________________________
  (indicate current user settings)
- [ ] Other: ______________________________

T · F · S™
Tools For Schools
Helping Children with Cochlear Implants Succeed in the Classroom

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