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: _____

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