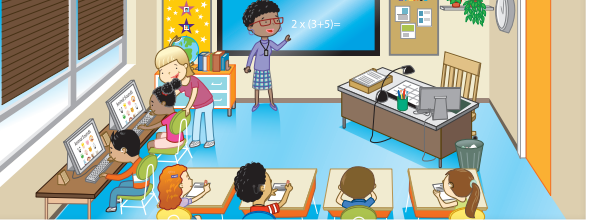

# TOOLS for SCHOOLS™

## **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: _____


### Advanced Bionics

For questions or additional information:

Toll Free Phone: 1-877-829-0026
TTY: 1-800-678-3575
Monday Through Friday, 5am to 5pm PST

*CustomerService@AdvancedBionics.com*
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