



1201 North 15th Street
Clarksburg, WV 26301-1936
304-624-6554 or 1-800-427-3600, Extension 221 or 228
FAX 304-624-5223

Referral Form

Please check one: [] Hearing Aid Check
[] Audiological Evaluation
[] Auditory Processing Evaluation

Referred by: _____ Date _____

Position: _____ Phone: _____

Address: _____

Reason for Referral: _____

Medical Card Number: _____

Please attach a copy of screening results (from student's permanent record health card), audiological reports (other than RESA), parental permission form, and classroom observation forms for auditory processing disorders.

Please check one: [] New Referral
[] Re-evaluation
(If re-evaluation, complete A & new information for B & C)

A. IDENTIFYING INFORMATION:

Pupil's Name: _____ Age: _____ DOB: _____ Sex: [] F [] M
Pupil's Address: _____ Home Phone: _____
Mother's Name: _____ Work Phone: _____
Father's Name: _____ Work Phone: _____
School: _____ Teacher: _____ Grade: _____ County: _____
Current special classes, programs, or services being provided: _____

B. HISTORY INFORMATION (complete to the best of your knowledge):

Impairments: [] Vision [] Speech [] Mental [] Emotional [] Other (Specify) _____
Ear Infections (dates of) _____ Ear: [] Left [] Right [] Both
Ear Surgery (dates of) _____ Ear: [] Left [] Right [] Both
Performed by: _____ Address: _____
Doe your child wear a hearing aid? [] Yes [] No If so, type: [] Body [] Ear Level [] Cochlear Implant
Make/Model: Left: _____ Right: _____
Date Received: Left: _____ Right: _____

C. TEST INFORMATION (need not complete if referral for Hearing Aid Check):

Date of initial screening: _____ Date of follow-up screening: _____
Was child cooperative during testing? [] Yes [] No Were responses consistent? [] Yes [] No
Prior audiological evaluations (dates of) _____
Relevant Observations and Comments: _____

Principal's Signature: _____ Date _____
Special Education Director's Signature: _____ Date _____
Person to contact to schedule appointment: _____ Phone: _____

REPORTS TO BE FORWARDED TO THE SPECIAL EDUCATION DIRECTOR LISTED BELOW:

Name & Complete Address: _____