Referral Form for Hearing Devices
Educational Service District 123 Audiology Program

Student Information:

Child's Full Name:

Address:

City / Zip:

Birthdate:

Gender: ☐ Male ☐ Female

Mother's Full Name:

Mother's Phone Number:

Email Address:

Father's Full Name:

Father's Phone Number:

Preferred Contact: ☐ Mother ☐ Father

Referral Source (person completing this form):

Name:

Title:

School:

Address:

Email Address:

Phone:

Parents were notified of this referral on (date) by (name):

Type of Hearing Loss:

Attach the following in the referral packet emailed to Betsy Schluge at audiologicalassessments@esd123.org or faxed to 509-544-5792:

- ☐ Release of Information
- ☐ Reports (ENT & Audiology) and audiogram
- ☐ Medical clearance to process with hearing aid devices (if student under 18 years of age)

Signatures:

Referral Source:

Date:

Authorized Administrator:

Date: