HEAR TO LEARN, LLC

EDUCATIONAL AUDIOLOGY REFERRAL FORM

Please send completed Referrals by email to info@heartolearnNH.com or fax to 603.513.2788

SCHOOL DISTRICT: _____DATE OF REFERRAL: _____

STUDENT NAME: _____DATE OF BIRTH: _____

TEACHER/CASE MANAGER:_____

CURRENT GRADE LEVEL: _____ SCHOOL: _____

PARENT/GUARDIAN NAME(S):_____

PARENT/GUARDIAN TELEPHONE: (H)_____(C)_____

PARENT/GUARDIAN EMAIL: _____

PLEASE SELECT ONE OF THE FOLLOWING:

- ☐ Review of records or Evaluation for a Student with a **Hearing Loss**
- ☐ Review of records or Evaluation for a Student with an **Auditory Processing Disorder (APD)**
- ☐ Request for **validation/verification** of hearing assistive technology
- ☐ Request for **Educational Audiology Consults** _____ (# hours)

PLEASE ATTACH THE FOLLOWING WITH ALL REFERRALS:

- Any previously completed Audiology or Hearing Evaluations
- Current IEP of 504, if student is currently classified
- Current (within 3 years) Speech-Language Evaluation Report *(APD Referral Only)*
- Current (within 3 years) Psychological or Psycho-Educational Evaluation Report *(APD Referral Only)*

_____ _____ _____

Special Services Director/Facilitator Signature Date

If you have any questions or require additional information about the referral process, please do not hesitate to contact:
Hear to Learn, LLC e: info@heartolearnNH.com t: 603.678.4543