Region 14 - Hopewell Center

Consultation/Evaluation Referral Packet for Children Ages 3 to 22 Years Old

Please use this packet to request the following Hopewell service(s):

Provide the child's name and District of Residence below. Please sign below and send this page along with all information listed for the Audiological Evaluation and/or Itinerant Teacher for the Deaf you are requesting. **Send to Region 14/Hopewell Center attention Mary Hiler. Thank you!**

_____ _____

Child's Name District of Residence

Audiological Evaluation and Itinerant Teacher for the Deaf

I am requesting Region 14 - Hopewell Center to provide the service(s) indicated with X below for;

_____ **Audiological Evaluation**

- Copy of Referral for Evaluation (Form PR-04) if this is an initial evaluation or a re-evaluation
- Permission to Consult – Enclosed
- Hearing Screening and Audiology Case History form

_____ **Itinerant teacher for the Deaf and Hard of Hearing Evaluation and Observation**

- Copy of Referral for Evaluation (Form PR-04) if this is an initial evaluation or a re-evaluation
- Permission to Consult – Enclosed
- Hearing Screening and Audiology Case History form
- If applicable please attach a copy of current IEP, 504, Service Plan, and ETR

Please indicate if student is Preschool or School Age, type of referral & due date:

_____ Preschool (All Day at least 4 days a week)
_____ Preschool (Half Day or a slightly modified weekly program)
_____ School Age

Transition Meeting due date _____
Initial Evaluation due date _____ (or) Re-evaluation due date _____
Has student been identified with a disability? ____ Yes ____ No Is student on an IEP? ____ Yes ____ No
Is student on a 504 ? _____ Yes _____ No Is student on a Service Plan ____Yes ____No
*Has the family obtained the Jon Peterson Scholarship? ____ Yes ____ No
Did your child attend a program such as Ohio Valley Voices, St. Rita, or the Regional Infant Hearing Program? (This also applies to a day care or private childcare program in the region).

_____ _____

District Contact Person Signature **Date**

CHILD'S INFORMATION BUILDING OF CURRENT ATTENDANCE

Name: _____ Date of Birth: _____

Gender: ____ Male ____ Female Grade: _____ Building of Attendance: _____

Teacher(S): _____, _____,

_____, _____

Home Address: _____ City/State/Zip: _____

Student's Native Language (if not English) _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Parent's Native Language (if not English) Street: _____

Reason for Referral:

EDUCATIONAL HISTORY: Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development.

Provide data from previous interventions, including Interventions required by rule 3301-35-06 or for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: _____ Years at present school building: _____

List schools/early childhood programs and dates: _____

_____

ATTENDANCE: _____ Regular _____ Irregular Is this student age-appropriate for grade level? ____ Yes ____ No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with _____ Vision _____ Hearing

Does the student _____ Wear Glasses _____ Use Hearing aid(s), Cochlear Implant(s)

When did the student start wearing glasses, hearing aid(s), or Cochlear implant(s)? _____

Does your child wear their hearing aids or Cochlear implant when they are at home and out in the community?
_____ Yes _____ No

How often does your child wear their hearing aid(s) or Cochlear Implant(s)? _____

Did your child have frequent ear infections or other ear issues? ____Yes ____ No

Does the student take medication? ____Yes ____ No

Does the student have any health/developmental/physical problems of which you are aware? ____Yes ____ No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school.

For Preschool Children Only (please check the area(s) of concern): ____ Eating ____ Dressing ____Toileting

____ Attention ____ Receptive Communication ____ Expressive Communication ____ Hearing

____ Gross Motor ____ Cognitive ____Fine Motor ____ Play ____ Vision ____ Social/Emotional Behavior

Other_____

_____

Describe any other pertinent information not previously described:

_____

_____

_____

_____	_____	_____
Signature of Person Initiating the Referral	Position or Relationship to Student	Date

_____	_____	_____
Signature of Person Receiving the Referral	Position of Person Receiving the Referral	Date

Date Received: _____ Date District Suspects a Disability: _____

Permission to Consult

I, _____, hereby give my permission for the
(Parent/Legal Guardian/Surrogate)

_____ to respond to a request for assistance
(School District)

for_____.
(Name of Child)

I am giving my permission for the following assessments (please check all that apply):

a. _____Review of relevant records (releases of information will be included)
b. _____Interviews with caregiver, myself, teacher
c. _____Observation(s) of my child
d. _____Assessment (e.g., curriculum-based, screening, and other appropriate measures to determine interventions)
e. _____Standardized assessments to assess (e.g., Auditory Processing Skills, Oral Expression, Listening Comprehension and other areas and other appropriate measures to determine skills and areas of weakness to design interventions.
f. _____Obtain video recordings to obtain observations and language measures to assess language skills.
g. _____Augmentative/Communication Evaluation (team decision-making process for communication technology, which includes meetings every 4 – 6 weeks, and may include trials of assistive technology and/or picture communication systems.)
h. _____Other (please specify): _____

I further understand and agree that the information collected by the school district will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

Name of Parent/Legal Guardian/Surrogate _____

Signature: _____ Date Permission to Consult: _____

HEARING SCREENING AND AUDIOLOGY CASE HISTORY
FORM HEARING SCREENING AND PHYSICIAN INFORMATION:

Student's Name: _____ Student's Physician: _____

Date of: _____ Screening: _____

Physician's Address: _____

Tester: _____ Physician's Phone: _____

SCREENING RESULTS (Circle one response for each ear)

RIGHT EAR: Pass Fail LEFT EAR: Pass Fail Could Not Test

IF "could not test" WAS CIRCLED, PLEASE EXPLAIN WHY THE CHILD COULD NOT BE TESTED:

_____

_____

AUDIOLOGY CASE HISTORY FORM 1.

What kind of hearing problem do you feel your child has?

_____

_____

2. Has your child had his or her hearing tested before or seen a doctor about his or her ears? _____ If so, what did you find out?

_____

_____

3. Has your child ever had any serious illness, high fevers, and/or blows to the head or significant noise exposure? If so, explain.

_____

_____

4. Were there any problems during the pregnancy and birth of your child?

_____

_____

5. Is there anyone else in the family with a hearing problem, hearing sensitivities (sensory), or auditory processing challenges?

_____

_____

6. Are your child's speech and language skills, social skills, academic skills, and general development similar to other children his or her age? _____If not, explain.

_____

_____

Report any additional information which you feel would be helpful here.

_____

_____

_____

How much screen time does your child have on an average day interacting with the television, computer, or tablet?

_____

_____

_____

Does your child wear headphones or ear buds? ____ Yes ____ No

Dear Parents/Guardians: We would like to notify you that Region 14 – Hopewell Center has become eligible to receive Medicaid reimbursement for Augmentative Communication, Audiological, Speech Therapy Service, Occupational Therapy Services, Physical Therapy Services and Psychological Assessments. Unless we receive a note of denial or a phone call from you, we will be billing Medicaid for your child.

Should you have any questions, please contact Mary Hiler at Region 14 – Hopewell Center by calling 937-393-1904 ext. 2280. Thank you.