Document Directions

HOWARD COUNTY
PUBLIC SCHOOL SYSTEM

Referral For Audiological Assessment

Department of Special Education and Student Services
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
Ellicott City, MD 21042

Student's Name: _____ Student ID Number: _____

School: _____ Grade:_____ Date of Birth: ___/___/____ Age: ____

Name of Parent/Guardian(s): _____ Home Phone #: _____

_____ Cell Phone #: _____
Address Street Apt. #

_____ Work Phone #: _____
City State Zip

IEP Team Referral Date: _____ _____
Signature of IEP Team Chairperson/Date

Special Education Information (If applicable.)

Disability: _____

Special Education Service Currently Provided: _____

Related Services Currently Provided: _____

Reason for Referral (Check the appropriate box below)

The student meets one the following criteria:

- ☐ Failure of a hearing screening and rescreening by the Howard County Health Department or HCPSS speech-language pathologist, and failure of a threshold screening administered by the speech-language pathologist
- ☐ Presence of a known sensorineural or chronic conductive hearing loss (with documentation)
- ☐ Suspected hearing loss in a student who could not be tested because of behavioral or developmental issues
- ☐ Presence of a medical condition, syndrome, or anomaly associated with hearing loss (e.g., Apert's, Down, Goldenhar's, Klippel-Feil, Treacher Collins, Turner's, and Usher's syndromes; cleft palate; meningitis)
- ☐ Other (with explanation) _____

COMMENTS

ATTACHMENTS

- ☐ Previous audiograms
- ☐ Hearing screening data
- ☐ Results of hearing screening or threshold screening
- ☐ Medical records or information
- ☐ Other pertinent information

Complete this form and fax (410-313-7049) or pony, along with attached documents, to the County Diagnostic Center, attn.: Audiology.

Distribution: County Diagnostic Center
Student Record (*Assessments and Evaluations* Folder)

September 2013