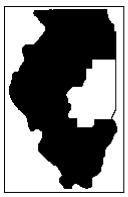

Central Affiliation for Special Education

CASE Audiology
809 N. Neil St. • Champaign, IL 61820
217/355-1214 or -1254 (phone) • 217/355-1265 (fax)

REFERRAL AND PERMISSION FOR AUDIOLOGICAL EVALUATION

Child's Name:_____ M / F (circle one) Birthdate:_____

Parent/Guardian's Name:_____ Contact phone number:_____

Email address:_____ Preferred contact method: ☐ voice ☐ text ☐ email

Home Address:_____ City:_____ Zip:_____

School:_____ Grade:_____ Teacher:_____

Reason for referral, concerns:_____

_____

_____

Please list other services currently received by student (e.g., speech/language, OT, PT, educational support, Early Intervention):

_____

_____

Language(s) used at home:_____

Additional comments: _____

_____

_____

I hereby give consent for the audiologist at CASE Audiology to evaluate the hearing status of my child.

_____ _____

Person Referring Child Date Signature of Parent/Guardian Date

Address: Comments:

_____ _____

_____ _____