EDUCATIONAL SERVICE CENTER
of Northeast Ohio

REFERRAL FOR STUDENTS WITH HEARING LOSS

School_____ Grade_____

District of Residence_____

School District of Service _____

Student Name_____DOB_____Age_____Sex_____

Home
Address_____City_____Zip_____Phone_____

Parent/Guardian Name_____

Name & title of person completing referral_____

Phone number of person completing referral _____ Email_____

PLEASE PROVIDE CURRENT AUDIOGRAM

Service provision will be determined by an evaluation/observation conducted by a teacher of the deaf (TOD) and /or educational audiologist in concert with IEP/504 team members at the district of residence.

1. Has the student already been found eligible for special education or a 504 plan? If so, please provide the most current ETR/IEP or 504 Plan. 2. Student's strengths and weaknesses? 3. Areas of concern.	**Services Requested– Check all that apply:** **_____Audiologist (consult, FM/DM services)** **_____Teacher of the Deaf (consult)** **_____Teacher of the Deaf (direct services)** **_____Assessment** **_____Training/Inservice** **_____Participation with Team Reports** **_____Other**

EACH REFERRAL MUST BE SIGNED BY BOTH PRINCIPAL & PUPIL SERVICES DIRECTOR

Name_____Date_____
Building Principal

Name_____Date_____
Director of Special Education/Pupil Services

Scan/e-mail, fax or mail requested reports to:

Dana Lambacher
Services for Students with Hearing Loss – Essex Place
Educational Service Center of Northeast Ohio
6393 Oak Tree Blvd., Independence, OH 44131
Fax: (216) 524-3683 E-mail: dana.lambacher@escneo.org